Local Administrator's Manual (LAM)

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CHOICE

Local Administrative Manual

Section 1 Introduction to The Local Choice (TLC)

Introduction to the Local Choice

Section 1.1: Introduction to TLC & Definitions

The Local Choice Health Benefits Program (TLC) was created exclusively for local governments, authorities, school divisions and constitutional officers. Launched on 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.

The program provides guidance and support to Local Administrators in the adoption, implementation and administration of the TLC program. The TLC program is governed under the Virginia Administrative Code "1VAC55-20-20". Regulations continue through "1VAC55-20-480".

Definitions

- **Department of Human Resource Management (DHRM)**
  The Commonwealth of Virginia's central source for information regarding the TLC Program.

- **Plan Administrator**
  A Plan Administrator, also known as a Third-Party Administrator (TPA), is an organization that provides claims administration.

  The Key Advantage plans and the TLC High Deductible Health Plan (HDHP) benefits are administered by Anthem Blue Cross and Blue Shield for Medical; routine vision, outpatient prescription drugs; and the behavioral health and Employee Assistance Program (EAP). Delta Dental of Virginia administers the routine diagnostic & preventive and comprehensive dental benefits.

  There are two Regional HMO plans available through TLC. The regional plans are administered by Kaiser Permanente and Sentara Health. The regional HMO plans are available only to participants who live or work in certain areas as defined by zip code.

  The Medicare Eligible Coordinating retiree plans are administered by Anthem Blue Cross and Blue Shield for medical, routine dental and routine vision.

- **Group Benefits Administrator**
  DHRM administers the TLC Program in cooperation with the local employer group which carries out the group-specific aspects of program administration.

Each local employer group has its own organizational structure for administering their Health Benefits Program. For many groups, responsibilities are shared by human resources and payroll/accounting staff. Further differences may occur when a group has branch offices and duties that are divided between the central office and branch offices.

We use the term "Group Benefits Administrator" to refer to the individual (or individuals) responsible for the duties associated with administering the TLC Program.

Group Benefits Administrators should be able to provide information about TLC benefits. If there is a conflict between what the Group Benefits Administrator tells a member and the health plan, benefits, to the extent permitted by law, will be determined on the basis of the language in this the member handbook and this manual.

- **The Local Choice Group**
  This means a local employer group participating in The Local Choice Health Benefits Program (TLC).

- **The Local Choice Health Benefits Program (TLC)**
  This is the health benefits program administered by DHRM for the benefit of local governments, local officers, teachers, commissions, public authorities and other organizations created by or under an act of the General Assembly. May include other organizations designated by the General Assembly.

- **The Local Administrative Manual (LAM)**
  This is the administrative manual for TLC Program. The LAM 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.

  Additionally, numbered memos are used to communicate benefits information to local employer groups. Numbered memos should be maintained by the Group Benefits Administrator until the local employer group is advised to disregard the information or advised that the information has been incorporated into the LAM. The health benefits specialists at DHRM are always available to assist you when an issue or question arises.

- **Cardinal HCM**
  Cardinal HCM is the eligibility system managed by DHRM. Cardinal HCM collects, validates, and distributes eligibility and enrollment data for both TLC and State Health Benefits Programs. It transfers data to plan administrators permitting access to benefits and payment of claims. It produces reports to help TLC groups reconcile data discrepancies and issue mandatory notices.

Introduction to the Local Choice

Section 1.2: HIPAA Privacy

The Office of Health Benefits Programs, as the health plan for The Local Choice (TLC), 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 and the local employer group.

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 local employer group's benefits office to all new hires and new plan participants, no later than 60 days after their enrollment into the TLC plan.

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 Local Choice Plan (TLC), and the agents acting on its behalf, as the group health plan (the "Plan"). For purposes of HIPAA the covered entity is The Local Choice and the plan is sponsored by **(Enter Name of Local Employer).**

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 any or all of the following plans; Medical, Prescription Drug, Dental, Behavioral Health and Vision plans . 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 Local Choice' ***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 past, present, or future physical or mental health condition or the past, present or future 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;
- notify you if you are affected by a breach of unsecured PHI; 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 Secretaries of Administration and Finance, and members of the General Assembly of Virginia 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 also use or disclose your PHI for underwriting and premium rating purposes, but the Plan does not use or disclose your PHI that is genetic information for underwriting purposes.

To The Commonwealth of Virginia. The Plan may disclose your PHI to designated 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 Commonwealth employee or department and (2) will not be used by the Commonwealth for any employment-related actions and decisions or in connection with any other employee benefit plan sponsored by the Commonwealth of Virginia.

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 use or disclose to your family member, other relative, your close personal friend, or other person you identify, PHI directly relevant to such person's involvement in your health care or payment related to your care. The Plan may use or disclose your PHI to notify a family member, your personal representative, or another person responsible for your care, about your location, condition, or death. In these situations, when you are present and not incapacitated, they will either (1) obtain your agreement; (2) provide you with an opportunity to disagree to the use or disclosure; or (3) using reasonable judgment, infer from the circumstances that you do not object to the disclosure. If you are not present, or you cannot agree or disagree to the use or disclosure due to incapacity or emergency circumstances, the Plan may use professional judgment to determine that the disclosure is in your best interests and disclose PHI relevant to such person's involvement in your care, payment related to your health care, or notification purposes. If you are deceased, the Plan may disclose PHI to such individuals involved in your care or payment for your health care prior to your death the PHI that is relevant to the individual's involvement, unless you have previously instructed the Plan otherwise.

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 facilitate specified government functions related to: (1) intelligence, counterintelligence and other national security activities authorized by law; (2) the provision of protective services to the President of the United States, members of the U.S. government or foreign heads of state, or to conduct special investigations; and (3) correctional institutions and other law enforcement custodial situations..

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.

Assist Victims of Abuse, Neglect, or Domestic Violence. The Plan may, under certain circumstances, disclose PHI about you if you are reasonably believed to be a victim of abuse, neglect, or domestic violence to a government authority, including a social service or protective services agency, authorized by law to receive such reports.

Certain Government-Approved Research Activities. The Plan may use or disclose PHI about you to research as provided under the Privacy Rule.

Breach of Unsecured PHI

You must be notified in the event of a breach of unsecured PHI that affects you. A "breach" is the acquisition, access, use, or disclosure of PHI in a manner that compromises the security or privacy of the PHI. If you are affected by a breach of unsecured PHI you must receive a notice of the breach as soon as possible and no later than 60 days after the discovery of the breach.

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, including your PHI maintained in an electronic format. This includes information about your plan eligibility, claim and appeal records, and billing records, but does not include psychotherapy notes. If your PHI is available in an electronic format, you may request access electronically.

To inspect and copy health information maintained by the Plan, submit your request in writing to the Privacy Official. The Plan may charge a fee for the cost of copying and/or mailing your request. But, this fee must be limited to the cost of labor involved in responding to your request if you requested access to an electronic

health record. 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," including a disclosure involving an electronic health record. This is a list of disclosures of your PHI that the Plan has made to others, except those necessary to carry out health care treatment, payment, or operations (Note: does not apply to electronic health records); disclosures made to you; or in certain other situations.

To request an accounting of disclosures, submit your request in writing to the Privacy Official. Your request must state a time period, which may not be longer than six years prior to the date the accounting was requested (three years in the case of a disclosure involving an electronic health record).

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.

Disclosure of PHI to a Personal Representative. You may request that the Plan disclose your PHI to your personal representative. A personal representative is an individual you designate to act on your behalf and make decisions about your health care. If you want the Plan to disclose your PHI to your personal representative, submit a written statement giving the Plan permission to release your PHI to your personal representative and documentation that this individual qualifies as your personal representative under state

law, such as a power of attorney. Submit this request in writing to the appropriate privacy contact listed below. The Plan may elect not to treat a person as your personal representation if (1) the Plan reasonably believes that you have been or may be subject to domestic violence, abuse or neglect by such person, or treating such person as your personal representative could endanger you; or (2) the Plan, using professional judgment, decides that it is not in your best interest to treat the person as your personal representative

Right to a Paper Copy of this Notice. You have the right to a paper copy of this notice, even if you received this Notice previously or agreed to receive this Notice electronically. 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 Benefits Office of each employer 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. Your written authorization is also required for:

- Most uses or disclosures of psychotherapy notes (where appropriate);
- Uses or disclosures of your health information for marketing purposes. Marketing does not include communications, involving no financial remuneration, for certain treatment or health care operations purposes, such as communications about entities that participate in a health plan network, health plan enhancements or replacements, case management or care coordination, or contacting individuals about treatment alternatives; and
- Disclosures of PHI that are considered a sale

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 Local Choice Program
c/o The Department of Human Resource Management
101 North 14th Street, 12th Floor
Richmond, VA 23219
804/225-2131

Notice Effective Date: January 1, 2003,
Revised effective September 23, 2013.

Introduction to the Local Choice

Section 1.3: Group Benefits Administrators

Definition of Group Benefits Administrator

The Department of Human Resource Management (DHRM) administers The Local Choice Health Benefits Program (TLC) in cooperation with the local employer group which carries out the group-specific aspects of program administration.

Each local employer group has its own organizational structure for administering their Health Benefits Program. For many groups, responsibilities are shared by human resources and payroll/accounting staff. Further differences may occur when a group has branch offices and duties that are divided between the central office and branch offices.

We use the term "Group Benefits Administrator" to refer to the individual (or individuals) responsible for the duties associated with administering the TLC health benefits program.

Responsibilities of a Group Benefits Administrator

If more than one person in a local employer group has responsibility for the TLC health benefits program, it is important for those involved to understand who has responsibility for each part of the program. The following is a brief summary of the scope of responsibilities in administering the program.

- ***Assist employees and retirees with enrollment and changes in plan or membership.*** The most important duty of the Group Benefits Administrator is to ensure that employees and retirees 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. It is important that employees understand that if enrolled in an HMO they must identify a Primary Care Physician (PCP) for each covered family member to obtain maximum benefit from their health benefits plan. A Group Benefits Administrator should be available to counsel an employee about the types of health benefits plans available to the employee. However, the Group Benefits Administrator should not advise an employee concerning which plan to choose. This is a decision each employee must make based on their needs.

  It is important to assure that all employees receive an open enrollment packet and all other health benefit publications distributed by TLC. These publications contain important information about the TLC Health Benefits Programs.

  If an employee does not apply for coverage (or changes in membership) within certain time limits, they may be disadvantaged by losing the opportunity to enroll in coverage or paying excess premiums. To help you provide counseling to your employees, we have outlined procedures to follow when certain events occur—an employee is hired, takes a leave of absence, retires, terminates, or has a change in eligibility status, etc.

- ***Be familiar with benefits and eligibility requirements.*** The Groups Benefits Administrator is the person to whom an employee will come when he has questions about his health benefits. In order to assist the employee, it's important that you be familiar with the general provisions of the health benefits offered under the various plans and all eligibility requirements.

  Group Benefits Administrators are one source for employee information on eligibility, policy and provisions. The TLC web site is another important source for information, plan handbooks, numbered memos, and other documents reside on this site. The address is www.thelocalchoice.virginia.gov.

  Group Benefits Administrators should advise employees that each plan has an appeals process and encourage them to work through this process if there are unresolved claims issues after contact with the plans' customer service units. Additionally, the Bureau of Insurance (BOI) has an Ombudsman who reviews appeals concerning medical necessity for the insured regional plans. Under the regulations of the self- funded statewide plan, there is an independent medical review appeals process, as well. An appeal may be directed to the Director of the DHRM once plan appeals are exhausted. Also, administrative appeals regarding eligibility and other non-plan issues may be made directly to the Director of DHRM. If there is an adverse determination at this level, an appellant may file an appeal under the provisions of the Administrative Process Act (APA).

- ***Report membership and plan information to the health benefits carriers.*** Most of the time, employees can make necessary enrollment changes through the Employer Self- Service (ESS) system which will carry the changes over to the Cardinal HCM Eligibility System.

  Any new enrollment or enrollment change not handled over the ESS system must be supported by the appropriate TLC form.

  Cardinal HCM serves as the enrollment and billing record for all TLC plans.

  Since carriers receive daily updates to their enrollment files, necessary changes to the Cardinal HCM record for enrollees of all plans should be reported accurately and promptly. Remember, an enrollee or his dependent could be denied admission to a hospital or have claims denied if there is no record of his membership.

  Monthly reconciliation, done by the Group Benefits Administrator, through analysis of Cardinal HCM reports is necessary to ensure the integrity of the eligibility system and to ensure that premiums are paid for all covered persons.

- ***Maintain confidentiality.*** Group Benefits Administrators must hold in confidence an enrollee's type of membership or plan, and especially safeguard information relating to an enrollee's medical services or claims.

- ***Encourage employees to help contain health care costs.*** With today's high cost for prescription drug and medical care, it is important that each of us do our part to use benefits wisely. This helps to hold down the claims experience for the group and to protect the group from unnecessary costs.

Introduction to the Local Choice

Section 1.4: Cost Containment

A third-party administrator (the Plan Administrator) processes claims and performs medical management and customer service functions for the self-insured TLC plans. The premiums for the self-insured plans depends upon the amount paid out in claims in the previous year, the trend of health care cost increases, and the surplus or deficit carried forward by the TLC Health Benefits Program. If less is paid in claims than was expected, the savings are passed on in the form of smaller increases in premiums. However, if claims payments are greater than expected, the loss must be made up through higher premiums.

Introduction to the Local Choice

Section 1.5: Description of Health Benefits Plans

The Local Choice Health Benefits Program (TLC) offers one of the most comprehensive selections of plans available in the Commonwealth and includes the plans listed below.

Active & Early Retiree (non-Medicare retiree) Plans

- Key Advantage Expanded
- Key Advantage 250
- Key Advantage 500
- Key Advantage 1000
- TLC High Deductible Health Plan (TLC HDHP)
- Kaiser Permanente HMO (regional plan only)
- Sentara Health Vantage HMO (regional plan only)

Medicare Coordinating Plans

- Advantage 65 – Medical only
- Advantage 65 with Dental/Vision
- Medicare Complementary (grandfathered plan)

Active Employee & Early Retiree (Non-Medicare Retiree) Group Plans:

The following is a basic overview of the active and early retiree plans offered by TLC. For more details, see the Comparison of Benefits brochure, the specific plan benefit summary or the applicable Member Handbook.

Statewide Self-Funded Plans: Key Advantage & TLC HDHP Plans

Medical, behavioral health, prescription drugs, and routine vision are administered by Anthem BCBS. Routine dental is administered by Delta Dental.

The following provisions apply to both Key Advantage and TLC HDHP Plans:

- Extensive medical, behavioral health, dental and routine vision benefits (through Blue View Vision) are covered in all Key Advantage and TLC HDHP plans.
- While members receive the highest level of benefits when visiting an in-network provider, members also receive out-of-network benefits for covered medical and behavioral health services but with higher out-of-pocket costs.
- These plans also allow for medical care when traveling outside Virginia through the BlueCard PPO and Blue Cross Blue Shield Global Core programs.
- In-network preventive medical care is covered with no deductible or coinsurance.
- Under the Employee Assistance Program (EAP), members receive up to four visits per incident per plan year at no cost. The EAP is only available in-network. Contact Anthem BCBS for more information.
- Home Delivery is also available through the plans' outpatient prescription drug benefits.

- In-Network Copayment/coinsurance expenses for outpatient prescription drugs along with medical and behavioral health copayments/coinsurance costs, accumulate toward the annual out-of-pocket maximum expense limit.
- Dental coverage is provided by Delta Dental with a separate deductible. Members may select either Preventive or Comprehensive Dental.

The following provisions apply only to Key Advantage Plans:

- Under the Key Advantage Plans, if members receive a brand name drug when a generic equivalent is available, they are responsible for the applicable brand copayment plus the cost difference between the allowable charge for the generic equivalent and the brand name.
- Outpatient prescription drugs are divided into 4 tiers based upon the cost and/or type of drug. See the Comparison of Benefits for more information.

The following provisions apply only to TLC HDHP Plan:

- The TLC HDHP plan is a HSA (Health Spending Account) compatible plan. TLC does not provide the HSA account. Each group may choose to offer its own HSA account administrator.
- With the embedded deductible TLC HDHP plan, deductible amounts for each individual member will accumulate toward the family plan year deductible limit. However, no individual family member can contribute more than the single- only deductible amount.
- Under the TLC HDHP plan, covered medical, behavioral health and prescription drug services are subject to the plan year deductible and 20% coinsurance.

Regional Plan: Kaiser Permanente HMO

- Kaiser Permanente offers a regional HMO plan in its service area, which includes Northern Virginia, Fredericksburg, Washington D.C., and parts of Maryland and is available only to members who live or work in those areas as defined by zip code. **Kaiser information is only provided in your renewal notebook if your group is eligible to offer Kaiser benefits.**
- A detailed outline of the service area and benefits may be found in the Kaiser HMO benefits summary. Medical, behavioral health, EAP, outpatient prescription drug and dental coverage are included in the plan.
- Retirees and / or their dependents eligible for Medicare are not eligible for enrollment in the Kaiser plan. Kaiser does not offer a Medicare supplement option in the TLC Program.

Regional Plan: Sentara Vantage HMO

- Sentara Health, a local health plan headquartered in Virginia, offers a regional HMO plan in its service area.
- Sentara Health's open-access style HMO plan does not require participants to select a primary care physician (PCP) and referrals are not required for specialist care. Sentara Health encourages a PCP relationship, but it is not required. PCPs can help members with routine medical care and provide guidance when seeking specialist care within the broad Sentara Health network of providers.
- A detailed outline of the service area and benefits may be found in the Sentara Health benefits summary. The TLC plan includes preventive care covered in full, dental and vision benefits, emergency travel assistance and Employee Assistance Program (EAP) services.
- In order to enroll in this plan, participants must be eligible for coverage as defined by their employer, employer must select this as a plan option and the participant must live or work in the defined service area. **Sentara information is only provided in your renewal notebook if your group is eligible to offer Kaiser benefits.**

- Retirees and /or their dependents eligible for Medicare are not eligible for enrollment in the Sentara Health plan. Sentara Health does not offer a Medicare supplement option in the TLC program.

To prevent claims denial and/or retraction of claims, it is imperative that you communicate the following information to all covered participants, whether active or retired.

Coverage under a Key Advantage Plan, the TLC HDHP or a Regional plan is only for:

- active employees and their dependents
- retirees not eligible for Medicare and their dependents not eligible for Medicare, and/or
- dependents of Medicare eligible retirees who are not Medicare eligible

Retirees eligible for Medicare and the Medicare eligible dependents of any retiree (whether the retiree is Medicare eligible or otherwise) may not enroll or remain in a Key Advantage or regional plan.

For more detail on the specific benefits of each TLC plan, please refer to the respective member handbook and Benefit Summaries.

Retirees must be terminated from the Active group. They cannot maintain coverage in your Active group. If retiree coverage is offered, the former employee has 31 days from the last date of Active employment to enroll in the appropriate retiree group (non-Medicare or Medicare-eligible groups).

Retirees Not Eligible for Medicare (Early Retirees) AND Medicare Eligible Retirees Plans (If Offered):

Retiree coverage is available but not automatically provided. If Retiree coverage is chosen, the employer may elect to cover retirees not eligible for Medicare (early retirees) only, or both early retirees and Medicare eligible retirees. 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. Employers are encouraged to contribute toward the cost of retiree coverage but they are not required to contribute.

Retirees Not Eligible for Medicare

- Employers may choose to offer retiree coverage for those retirees who are not eligible for Medicare. Although allowed, no employer contribution is required for retiree coverage. A local employer group employer may add retiree coverage at renewal by submitting a written request to DHRM along with an approved resolution from your Board or Governing Body. Adding such coverage may impact your group's renewal rates. All groups (with exception of groups that have been grandfathered) will receive rates for blended premiums. In a blended premium, active employees and non-Medicare-eligible retirees will have the same rates.
- Stand-alone rates for non-Medicare-eligible retirees are grandfathered, which means that they are only available for groups who currently offer them.

Medicare Supplemental Plans for Medicare-Eligible Retirees

- The Medicare supplement and routine dental and vision (if selected) are administered by Anthem BCBS.
- If a group offers coverage to retirees who are not eligible for Medicare, the group may also offer coverage for Medicare-eligible retirees. A local employer may add coverage for Medicare-eligible retirees at renewal by submitting a written request to the Department of Human Resource Management (DHRM) along with an approved resolution from their Board or Governing Body.

- For groups currently offering coverage to Medicare-eligible retirees, the Advantage 65 and Advantage 65 with Dental/Vision plans continue to be available. However, Medicare Complementary is a grandfathered plan and not available to groups that do not currently offer it.
- Groups adding Medicare-eligible retiree benefits to their program for the first time may only offer Advantage 65 or Advantage 65 with Dental/Vision. It is important to remember that a local employer group may select only one plan for Medicare-eligible retirees.
- A local employer may also add Dental/Vision coverage to a current Advantage 65 contract at the group level at renewal. Once added, however, it may not be removed.

Enrollees in TLC Medicare Coordinating plans must be enrolled in **Medicare Parts A and B** as the primary payer of Medicare-covered services. Neither the Advantage 65 nor Medicare Complementary Plans will pay for any services that would have been covered by Medicare had the participant been properly enrolled.

Outpatient prescription drug coverage is not available in any of the Medicare supplemental plans. If prescription drug coverage is desired, members should seek coverage in Medicare Part D.

Medicare eligible retirees may not remain in an active plan. If they participate, it must be in one of the Medicare-coordinating plans.

Available Medicare Eligible Coordinating Plans:
The following are self-insured plans available to Medicare eligible retirees and their covered Medicare eligible family members. These plans do not provide full-coverage for most medical care; they simply pay some of the Medicare deductibles and coinsurance. These plans do not provide outpatient prescription drug benefits.

A local employer group may select only one retiree plan option. Employees will not be allowed to pick the plan they desire.

- **Advantage 65-Medical Only**
  Anthem BCBS administers the supplemental medical and behavioral health benefits under the Advantage 65-Medical Only plan.

- **Advantage 65 with Dental/Vision**
  As a group option, you may elect to add Dental/Vision coverage to Advantage 65-Medical Only. This product provides Advantage 65 medical and behavioral health coverage plus dental and vision coverage. Anthem BCBS administers the supplemental medical, behavioral health, routine vision benefits and routine dental coverage.

- **Medicare Complementary (grandfathered at group level)**
  Medicare Complementary is a "grandfathered" plan available only to groups who already offer the product. It is not available to any group not currently offering this coverage. This plan provides supplemental medical and behavioral health benefits, plus dental and vision coverage. Anthem BCBS administers the supplemental medical, behavioral health, routine vision benefits and routine dental coverage.

  If the local employer group terminates Medicare Complementary, it may not be offered again.

The TLC Regional HMO Plans (Kaiser Permanente and Sentara Health) are not available to Medicare eligible retirees or their Medicare eligible family members.

All Plans

- There are no pre-existing exclusions in any TL C medical plan.
- TLC does not offer credit for previously satisfied deductibles or out-of-pocket maximum limits incurred with a prior plan.

Available Types of Membership
Employees may choose from three types of membership:

Membership type...	Covers...
Single	Only the employee or retiree (Early and Medicare eligible retirees)
Plus One (or dual)	Covers the employee or early retiree and one eligible family member
Family	Covers the employee or early retiree plus two or more dependents

Value Added Benefits
Please see the member handbooks for Value Added Benefits (Programs Included in Your Health Plan) that are included in the TLC plans.

Introduction to the Local Choice

Section 1.6: Group Imposed Waiting Periods

While waiting periods of up to 90 days are permitted under the Affordable Care Act (ACA), they cannot exceed 60 days under The Local Choice (TLC) program.

Group Imposed Waiting Periods are permissible as long as they are consistently applied to all employees. If applicable, coverage begins on the first day of the month following completion of the waiting period.

Introduction to the Local Choice

Section 1.7: Retroactivity

Retroactivity

Limited retroactivity is allowed to correct health plan elections. All requests for changes outside of the 60-day window must be submitted in writing by the Group Benefits Administrator to The Department of Human Resource Management (DHRM) Office of Health Benefits for consideration based on DHRM policy, IRS regulations imposed on cafeteria (pre-tax) plans, and contractual limitations (12 months maximum retroactivity for self-insured plans and 60-days for the fully insured plan). Local Employer Groups should be aware that an employee may wish to seek remedy from the Local Employer Group in the case of agency error if the period of retroactivity does not afford the employee full remedy.

Premium refunds to local employer groups that result from a clear and convincing error will be based upon a correction of the corresponding Cardinal record. In most cases, the Local Choice Health Benefits Program (TLC) will not authorize retroactive refunds beyond the 12 months.

In the case of enrollment in error of an ineligible person, the Administrative Code of Virginia (1VAC55-20-210.B) states: Employer contributions on behalf of ineligible persons shall not be returned to the local employer group 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.

Introduction to the Local Choice

Section 1.8: Premium Refunds

Premium Refunds

Premium refunds that result from a local employer group error will be based on the error. In most cases, DHRM/TLC will not authorize retroactive refunds beyond the 60-day limited retroactivity. Premium refunds to Local Employer Groups that result from a clear and convincing error will be based upon a correction of the corresponding Cardinal record. In most cases, the TLC Program will not authorize retroactive refunds beyond the 12 months.

Section 2 Eligibility

Eligibility

Section 2.1: Eligible Employees

The Local Employer Group 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 local employer groups** are eligible to participate in the Program. A full-time salaried employee is one who is scheduled to work at least 30 hours per week or carries a faculty teaching load considered to be full time at his or her locality.

- **Part-time employees of participating local employer groups** - some or all classifications of part-time employees 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. A part-time employee is eligible if scheduled to work at least 20 hours per week.

- **Retired employees** - TLC eligibility will mirror the retirement requirements of the Virginia Retirement System (VRS) - even if the local employer group does not participate with VRS.

  The requirements for eligibility are:

  1) 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:

  2) At least 55 years of age, have at least five (5) years of service with the participating employer or at least 50 years of age with at least ten (10) years of service with the participating employer.

  3) A retiring employee must apply for retiree health benefits within 31 days of the separation from active service.

     - Retirees eligible for coverage in the plan but not eligible for Medicare:
       Retiree may elect coverage under the active health plan.

     - Retirees eligible for coverage in the plan and eligible for Medicare:
       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.

Local employer groups new to TLC
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 TLC retiree plans.

Elected Officials
Elected officials that make up the governing body of a local employer may be eligible as either a special class of full-time employees or as part-time employees. They may not, however, participate in the retiree classification.

Classifications Not Eligible for Coverage
The following are not eligible for coverage under TLC:

- Temporary employees
- Appointed board members
- Appointed commissions

Eligibility

Section 2.2: When Coverage Begins and Ends

When Coverage Begins
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.

The employee has 30 days from the date of hire to enroll in a health benefits plan for coverage to be effective at the earliest date available.

Example:

- Employee is hired on February 10 and the local employer receives the enrollment action on February 18. Coverage is effective March 1.
- Employee is hired on February 10 and the local employer receives the enrollment action on March 5. Coverage is effective on March 1.

However, if the employee's start date is the first day of the month and, if an election action is received within 30 calendar days, coverage for the employee will commence on the first day of that month. New employees must enroll for coverage within 30 days of the beginning of employment.

Example:

- Employee is hired on May 2 and agency receives the enrollment action within 30 calendar days. Coverage is effective June 1.
- Employee is hired on May 1 and agency receives the enrollment action within 30 calendar days. Coverage is effective May 1.

There is no discretion allowed in this area. Coverage will always be effective as described above. In no case will coverage begin before the eligible employee's first day of employment or eligibility

A probationary or waiting period before the Effective Date may be applied if uniform for all employees. Waiting periods may not exceed 59 days.

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.

When Coverage Ends
Coverage terminations are effective the end of the month in which an employee terminates employment as long as the premium is paid in full. 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.

When coverage ends, the COBRA administrator (Inspira Financial) will determine if the event invokes an offer of COBRA. See the COBRA (Extended Coverage) section of this manual for more informaton.

Eligibility

Section 2.3: Types of Membership

Types of Membership

Single Membership
Single membership covers only the employee or retiree.

Employee Plus One Membership
Covers the employee or early retiree and either the spouse or one other eligible dependent may be covered.

Family Membership
Covers the employee or early retiree plus two or more dependents.

Who Is Eligible for Coverage
See the Eligibility, Enrollment and Changes section of the Local Choice Health Benefits Program (TLC) Member Handbook for the most current information regarding who is eligible for coverage and required documentation.

Types of Dependents Not Eligible for Coverage
There are certain categories of persons who may not be covered as dependents under the program. These include dependent siblings, grandchildren, nieces, and nephews except where the criteria for "other children" are satisfied. Parents, grandparents, aunts, and uncles and any other individuals not specifically listed as eligible in the Eligibility, Enrollment and Changes section of the TLC member handbook are not eligible for coverage regardless of dependency status.

You cannot cover a person as a dependent unless that person is a U.S. citizen, U.S. resident alien, U.S. national, or a resident of Canada or Mexico. However, there is an exception for certain adopted children. If you are a U.S. citizen or U.S. national who has legally adopted a child who is not a U.S. citizen, U.S. resident alien, or U.S. national, you may cover the child, if the child lives with you as a member of your household. This exception also applies if the child was lawfully placed with you for legal adoption.

Failure To Remove Ineligible Persons
Participants who enroll or fail to remove ineligible persons within the timeframe allowed by the group's flexible benefits document and no later than 60 days from the dependent's loss of eligibility may be excluded from the program for a period of up to three years. In addition, the participant will be responsible for claims paid in error and will be unable to reduce health benefits membership except during open enrollment or with a consistent qualifying mid-year event.

Eligibility

Section 2.4: Active Employees & Family Members Eligible for Medicare

Medicare Eligibility of Active Employees

While most beneficiaries become eligible for Medicare at age 65, Medicare eligibility due to disability or certain specific health conditions can occur at any age. This section discusses the impact of Medicare eligibility on active employees and their family members who are covered under The Local Choice Health Benefits program (TLC).

Medicare Coordinating Plans are not offered to active employees and their dependents even if eligible for Medicare (see Medicare Eligibility due to End Stage Renal Disease (ESRD) for exception). Benefit plans and rates remain the same as other active employees. Local employer group contributions continue.

Qualifying Mid-Year Event (QME)
Medicare entitlement (eligibility plus enrollment) is a qualifying mid-year event. For the employee, this would be consistent with terminating coverage if it is reported within the required notification period for a QME as defined by the local employer group. Termination of the employee's coverage would result in termination of all covered family members. For a covered family member, it would be consistent with decreasing membership (removing the Medicare-entitled family member) if reported within 60 days of the event. Beneficiaries may choose to drop the TLC plan in favor of Medicare. However, before making that decision, they should consider the cost of TLC health plan coverage, the cost of Medicare, the possible cost of a Medicare supplement or Medicare Health Plan, and coverage needs for family members. They should compare the associated out-of-pocket costs under the TLC plan versus Medicare as primary payer. Reviewing the results of these comparisons should help in making the best coverage decision.

An **active employee's dependents that are eligible for Medicare** may choose to remain in the active health plan and the plan will be their primary insurance. The dependent will remain in the active health plan until the employee retires (whether as an early retiree or a Medicare eligible retiree). Upon the employee's retirement, the dependent eligible for Medicare MUST be removed from the active plan. If offered by the local employer group, the dependent will be eligible to join the TLC Medicare Coordinating Plan.

Coordination of Benefits/Medicare Parts A and B

If a Medicare-eligible active employee (or the active employee's family member) maintains coverage in the TLC Health Benefits Program, the TLC program will usually be the primary payer of claims (see End Stage Renal Disease exception).

For most beneficiaries, Medicare Part A (hospital insurance) is free. Because of this, many active employee beneficiaries will enroll in Part A even if they maintain the TLC program as their primary coverage. However, Medicare Part B (medical insurance) requires the payment of a monthly premium. Beneficiaries who maintain coverage due to current employment are allowed to defer Part B coverage as long as they continue to maintain their active employee coverage.

They may exercise a Part B Special Enrollment Period at any time while they are covered based on current employment or during the eight months that follow the loss of that coverage (including retirement). If a Special Enrollment Period is available for enrollment in Part B, there is generally no penalty for late enrollment (enrollment after initial eligibility).

Beneficiaries may contact the Social Security Administration (1-800-772-1213) to address Medicare enrollment questions. Also, the annual "Medicare and You" publication provides eligibility and enrollment information for beneficiaries. Finally, the Medicare web site (www.medicare.gov) or 1-800-MEDICARE can provide answers to specific Medicare questions.

Medicare Eligibility due to End Stage Renal Disease (ESRD)

There is an exception to the coordination of benefits guidance provided previously. Active employees and their family members who are covered under the TLC Health Benefits Program and become eligible for Medicare due to ESRD (permanent kidney failure) will maintain primary coverage under the TLC program during a 30-month coordination period. However, after that period is exhausted, Medicare becomes the primary payer, even if the coverage is due to active employment.

The end of the coordination period provides an opportunity for enrollment in Medicare Part B (which may be declined without penalty during the coordination period). The Department of Human Resource Management's (DHRM) Office of Health Benefits monitors Medicare eligibility due to ESRD. Once the coordination period ends, covered employees or their family members must enroll in Medicare Part B to ensure primary payment. DHRM's Office of Health Benefits will reimburse the cost for any Part B premium required due to the end of the coordination period as long as eligibility due to ESRD continues for active employees or family members. Contact DHRM for instructions to facilitate reimbursement. Failure to enroll in Medicare Part B once it should become the primary payer can result in a gap in coverage.

Medicare and Retiree Coverage

The impact of Medicare eligibility on retiree group participants (those covered based on former employment) differs completely from that of active employees since Medicare almost always becomes the primary payer for retirees. Please refer the Retiree Health Benefits section of this manual for information about the impact of Medicare eligibility on retiree coverage.

Prescription Drug Coverage – Part D

TLC Medicare Coordinating Plans do not provide coverage for Outpatient Prescription Drugs.

Eligibility

Section 2.5: Retiree Health Benefits

Benefit Administrator's Role at Retirement
The Benefits Administrator should assist eligible employees who are retiring with enrollment in the retiree group (including survivors of active employees).

- Provide an enrollment form. If the retiree does not wish to enroll in retiree coverage, encourage him or her to indicate this on the enrollment form to document the offer and rejection.
- Provide premium information and explain group billing or direct billing as appropriate.

Retiree coverage is available but not automatically provided. A local employer group is not required to offer coverage. If retiree coverage is chosen, the employer may elect to cover retirees not eligible for Medicare (early retirees) only, or both early retirees and Medicare eligible retirees. 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.

Participants in this program (the retiree group) include retirees (also referred to as Enrollees) and their eligible covered family members. In general, these are former employees and their family members who are covered based on that former (not current) employment. Coverage based on former employment is an important distinction that will be discussed later in this section as it relates to coordination of benefits with Medicare.

Medicare eligible retirees may not remain in an active plan. If they participate, it must be in one of the Medicare-coordinating plans.

Elected officials that makeup the governing body of a local employer are not eligible for coverage in the retiree plan.

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

Eligibility for Retiree Coverage
To enroll in the TLC retiree health benefits plan, a retiring employee must:

- meet VRS requirements and the local employer's criteria for retirement to be eligible for health benefits coverage through the employer retiree group (See the Eligible Employees section of this manual);

- be eligible for coverage as an active employee up to the retirement date; and

- apply within 31 days of termination of employment. 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.

The only exceptions which allow for enrollment after 31 days from the retirement date are:

- TLC retirees who properly waive retiree coverage within 31 days of their retirement date to enroll as an eligible family member on their spouse's active employee or retiree health benefits membership under the same local employer may enroll in the retiree group within 31 days of the loss of that coverage. Failure of the retiree to submit a waiver at the time of retirement may result in lack of documentation to support continuous eligibility for the TLC program, which could preclude future retiree enrollment. To waive coverage, submit an enrollment form indicating the waiver. To ensure continuous coverage, the retiree should enroll in the spouse's plan in time to generate an effective date equal to his/her retirement date.

- Under certain circumstances, retroactive approval of a disability retirement may allow for enrollment within 31 days of the approval notification letter.

Local employer groups new to TLC: 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 TLC health plans.

Enrollment
New retirees who wish to participate in the retiree health plan must submit an Enrollment Form to their Group Benefits Administrator within 31 days of their retirement date. Group Benefits Administrators should also have eligible new retirees who do not wish to enroll in retiree coverage to complete this form to confirm that they have declined/waived coverage, which will avoid potential conflicts later. However, failure to enroll within the 31- day window effectively ends eligibility for enrollment in the retiree group.

Effective Date of Coverage
If it is determined that a retiree is eligible, and enrollment occurs within 31 days of the retirement date, retiree coverage will begin on the first day of the first full month of retirement—no break in coverage (or eligibility for coverage).

Enrollment in retiree coverage is not prospective to the date of enrollment.

Initial Enrollment Limitations – No Retroactive Changes to Retirement Elections
- Except as specifically allowed, if an enrollment form is not submitted to the designated Group Benefits Administrator within 31 days of the non-deferred retirement date, the opportunity to enroll in the retiree program is lost.

- Once an enrollment has gone into effect (including declining coverage), there can be no change to that enrollment, except as specifically allowed by the program, even if it is within the initial 31-day enrollment window. If they elect prior to the retirement date and the coverage goes into effect (including declining coverage), it may not be changed retroactively, even if it is within the 31 days after retirement.

- Elections made prior to the retirement date may be changed until the coverage goes into effect.

When assisting retiring employees in advance of their retirement date, remind them to ensure that their election is accurate prior to its effective date.

Elections can be changed prospectively due to consistent qualifying mid-year events, at open enrollment (non-Medicare only), or based on law or specific policy. Certain HIPAA special enrollments can be effective retroactively.

Extended Coverage
If an employee retires and loses active health plan coverage, they must be offered Extended Coverage/COBRA (if eligible) since retirement is a termination of employment, and loss of the employer contribution toward the cost of coverage is a change in the terms and conditions of coverage and, therefore, a loss of coverage. While it is generally, but not always, beneficial to elect retiree coverage instead of Extended Coverage (due to additional Extended Coverage administrative cost and a finite coverage period), offer of retiree coverage does not relieve the requirement to offer Extended Coverage. Failure to offer Extended Coverage under these circumstances can result in significant liability to the program.

If the new retiree group Enrollee had coverage as an active employee, a COBRA Election Notice must be provided, even if retiree group coverage is available and elected. This notice will be provided by the COBRA administrator for TLC. For more information, see the Extended Coverage/COBRA section of this manual.

Family Member Eligibility
Eligibility criteria for spouses and children of retirees are the same as those for active employees.

Local Retirees
Based on contract or legislative provisions, some retirees are eligible for coverage in the State Retiree Health Benefits Program even though they are covered under a locality's retirement program. Those covered under these special provisions will continue to be administered by their employing entity after retirement.

Plan Choices
Retiree plan choices are dependent on whether the retiree and/or their covered family members are eligible for Medicare. Non-Medicare retirees/family members may choose from the same plan(s) as those offered to active employees.

Medicare eligible retirees may not remain in an active plan. Medicare eligible retirees/family members must choose a plan that coordinates with Medicare. A local employer may select only one Medicare-Coordinating Plan option. Employees will not be allowed to pick the plan they desire.

Available Medicare-Coordinating Plans include:

- Advantage 65 – a Medicare coordinating plan that pays after Medicare's primary payment for Medicare-covered services. It includes some additional benefits that are not covered by Medicare. These additional benefits are specifically explained in the Member Handbook and include out-of-country major medical benefits and at-home recovery care and visits. This plan does not include Part D prescription drug services or routine dental/vision services.

- Advantage 65 with Dental/Vision – the same Medicare supplement plan described above, with the addition of routine dental and vision benefits.

  Medicare Complementary (grandfathered at group level) – this plan is a "grandfathered" plan available only to groups who already offer the product. It is not available to any group not currently offering this coverage. If the local employer terminates Medicare Complementary, it may not be offered again.

  This plan pays after Medicare's primary payment for Medicare-covered services. It includes some additional benefits that are not covered by Medicare. These additional benefits are specifically explained in the Member Handbook and include routine dental and vision, out-of-country major medical benefits and at-home recovery care and visits. This plan does not include Part D prescription drug services.

The Medicare Coordinating plans do not offer a prescription Part D coverage.

The Medicare-Coordinating Plans Member Handbook, along with the insert for routine Dental/Vision coverage, describes the specific benefits of these plans.

Changes Allowed at Retirement
New eligible retirees may maintain their existing plan (unless they or their covered family members are eligible for Medicare) and/or membership or make the following changes:

- Decrease membership (no increase unless there is a consistent qualifying mid-year event that would allow the addition)
- Enroll from active waive into single coverage
- Change plans
- Waive to be covered as a family member in their spouse's active plan through the same employer (until Medicare eligibility results in a split contract)
- Decline coverage (retirees who cancel or decline coverage may not return to the plan in the future)

Required Changes at Retirement
If any new retiree group participant (enrollee or covered family member) is eligible for Medicare, to remain in the TLC health plan, they must select the Medicare-Coordinating Plan (if offered), and Medicare will become the primary payer (except in limited circumstances where the beneficiary is eligible due to End Stage Renal Disease and is still in the coordination period). Medicare will adjudicate all primary claims for Medicare covered services. If the plan includes the dental/vision option, the TLC plan will remain primary for those services since Medicare does not generally cover routine dental and vision. More information about Medicare is provided later in this section.

Waiving Coverage at Retirement
Generally, failure to enroll in retiree coverage within 31 days of the retirement date will result in loss of eligibility for the retiree program. However, new retirees who are eligible to be covered as a family member under the active employee plan or through the membership of another retiree can waive coverage, thereby maintaining his own eligibility. This allows two enrollees through the same employer to receive the benefit of dual or family membership instead of the additional cost associated with two single memberships, a single and a dual, etc. When family member eligibility is lost, the retiree may re-enroll in the retiree program in his own right only within 31 days of the loss of that status with no break in TLC program coverage.

When a retiree becomes eligible for Medicare, he will be moved back to his own membership since all Medicare memberships are single and, therefore, there is no premium benefit to maintaining family member status.

Be sure to get an enrollment form requesting the waiver within 31 days of the retirement date in order to establish the waive record in Cardinal.

When moving a retiree from family member to retiree status in his own right, be sure to confirm continuous program enrollment. A break in coverage will result in loss of eligibility to enroll in the retiree program.

Changes Allowed After Enrollment in the Retiree Group
- Membership can be cancelled at any time prospectively—no return to the program.

- Membership can be reduced (family members dropped) at any time prospectively.

- Eligible family members can be added based on consistent qualifying mid- year events, including HIPAA Special Enrollments, if the request is made within 60 days of the event.

- Eligible family members can be added at Open Enrollment by non-Medicare retiree group enrollees. (Medicare-eligible enrollees do not have an open enrollment except that they may make an open enrollment election to add eligible non-Medicare family members effective July 1 or October 1 if their initial move to Medicare-primary coverage is also July 1 or October 1. After that, there is no open enrollment available for making membership increases.)

Retiree Group Participant Who Becomes Eligible for Coverage as An Active Employee
In most cases, retiree group participants who become eligible for coverage as active employees through the same employer group must leave the retiree program and enroll in the active employee coverage. This will require completion of an enrollment form. For those eligible for Medicare, it will result in moving from a Medicare-coordinating plan to a non-Medicare plan. Some examples are listed below:

- Retirees enrolled in the TLC Retiree Health Benefits Program who return to work in a part-time classified position will be required to enroll in the active plan if they wish to continue coverage under the TLC program. This will result in a pre-tax benefit for those whose pay supports the full amount of their premium by payroll deduction. If the employee's part-time pay is not sufficient to cover the premium obligation, the premium will need to be paid directly to the agency payroll office. Those individuals who have been enrolled in a Medicare-coordinating plan based on their retiree coverage would be covered in a non-Medicare plan by virtue of their coverage as current, active employees. Under those circumstances, employees may wish to contact Medicare to discuss suspension of their Part B coverage. Upon retirement from the part-time classified position, re-enrollment in retiree coverage must be completed within 31 days of the loss of active coverage. At that time, all retiree eligibility criteria and retiree program provisions will again apply.

- *Covered spouses in the retiree group who are hired as part-time classified employees must enroll in the active plan in order to continue their state coverage. The retiree may choose to waive his/her retiree coverage to be covered as a family member under the active spouse's plan or may choose to remain in retiree coverage. Under these circumstances, retirees should review the benefits of active versus retiree coverage. If the spouse is hired as a full-time employee, eligibility for the employer contribution would suggest that coverage as a family member is generally to the retiree's advantage, and a waiver of retiree coverage would allow re-enrollment in the retiree group within 31 days of the loss of that coverage.

- *Covered children in the retiree group who are hired as full-time or part- time classified employees must enroll in the active plan in order to continue their state coverage. The only exception would be if the child were covered in a family contract of four or more family members, and dropping one family member would not decrease the family membership level. In that case, the employee would be allowed to waive coverage in the active group until his/her termination in the family membership would result in a lower retiree premium.

- A retiree who has waived his/her own retiree coverage to be a covered family member of his/her spouse who is also a state retiree and then resumes employment on a part-time classified basis may choose to be covered in his/her own right as a retiree or continue his/her waiver as a family member under the active spouse's coverage. Under these circumstances, retirees should review the benefits of active versus retiree coverage.

- Survivors covered under the TLC Retiree Health Benefits Program who accept positions as full-time or part-time employees must terminate their retiree group coverage and enroll in the current employer's active employee plan. However, upon termination of employment, they will be allowed

to re-enroll as survivors as long as they do so within 31 days of their loss of active coverage. In addition, the Survivor must have maintained continuous coverage in the TLC Health Benefits program; and, are otherwise eligible for coverage based on the eligibility provisions for annuitant or non-annuitant survivors, as applicable. If they accrue enough service to retire, and they meet all of the other eligibility requirements for retiree coverage, they may, of course, enroll in their own right as retirees.

*Some exceptions may apply if enrollment in the active group results in a higher premium cost.

When Medicare is Primary
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 (ESRD). It is a Federal Government program administered by the **Centers for Medicare and Medicaid Services (CMS)**. Both **TLC** 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. Both Part A and B of Medicare must be secured in order to get maximum benefits from the plan. If enrolling in TLC as a retiree, the Medicare eligible retiree must enroll in a TLC self-funded plan that coordinates with Medicare.

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 from 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.

Medicare and the TLC Retiree Health Benefits Program
Once a Medicare-eligible participant in the TLC Health Benefits Program ceases to be covered based on current employment (e.g., at retirement, survivorship, long-term disability), Medicare will be the primary payer of Medicare-covered claims, and a Medicare-coordinating plan must be chosen (if offered). These plans include:

A few more notes about Medicare-coordinating plans:
- Medicare eligible retirees become ineligible for coverage under the plans offered to active employees.
- These plans are not available to active employees or their eligible family members who are also eligible for Medicare (see the Active Employees and Family Members Eligible for Medicare section of this manual).
- Routine dental and vision coverage are not covered by Medicare, so any claims for these benefits should be filed directly with the plan administrator for those whose plan contains this option.
- The dental benefits under the dental/vision option available to Medicare- eligible retiree group participants are not the same as those covered under the non-Medicare plan options. A description of these benefits is available in the Dental/Vision Medicare-Coordinating Plans Member Handbook Insert. A pre-treatment estimate is always advisable, especially for basic and major dental care.
- All Medicare-coordinating plan memberships are single so that they coordinate with the individual's Medicare eligibility.
- Medicare eligibility due to age is the first of the month in which a beneficiary turns age 65 or the first of the previous month if the date of birth is on the first of the month.
- No plan covers services not covered by Medicare as primary payer, except as specifically described in the Member Handbook (e.g., Out-of-Country Major Medical benefits). If Medicare

denies the claim and the plan does not specifically cover the service, the claim will be denied by the TLC plan for secondary payment.
- To enroll in Medicare, beneficiaries must contact the Social Security Administration by calling 800-772-1213 or going to www.ssa.gov.

Communications Received from Medicare
Local Employer Groups receiving any requests for employee health plan information from the Centers for Medicare and Medicaid Services (CMS), the Medicare Secondary Payer Recovery Contractor (MSPRC), or any of their contractors, including collection agencies, should forward them immediately to DHRM's Office of Health Benefits for handling. This includes Primary Payment Notices, which provide an opportunity to resolve Medicare Secondary Payer Debts (the result of incorrect coordination of benefits information at Medicare) before they move to a collection status.

Split Contracts and Linked Family Members
Because all Medicare-coordinating plans include only single memberships, covered family members in the retiree group who are eligible for Medicare or who are covered based on the eligibility of a Medicare-eligible enrollee/original participant must have their own membership and their own ID number. These family members are "linked" (e.g., linked child, linked spouse) in the Cardinal HCM to the original participant (the Enrollee through whom eligibility is obtained), and this is called a split contract. Despite their own ID numbers, they are still treated as family members and rely on eligibility of the original participant to remain covered.

Family groups that are split between Medicare and non-Medicare plans must pay the appropriate premium for each plan except that a family group will not have to pay a total premium that is greater than the family membership level for the non- Medicare plan. For example, a family in which one member is eligible for Medicare and three members are not eligible for Medicare will pay only the family premium for the non-Medicare plan.

Coordination of Benefits with Medicare
For Medicare-eligible participants, the TLC Retiree Health Benefits Program coordinates with Original Medicare. This includes Part A (hospital insurance) and Part B (medical insurance). It does not coordinate with Part C, which generally includes the Medicare Advantage plans. TLC's Medicare-coordinating plans specifically exclude services covered by a Medicare Advantage Plan, so if a participant enrolls in Part C, there will generally be minimal if any value to their Advantage 65/Med Comp coverage.

When a Medicare beneficiary is no longer covered based on current employment and enrolls in the TLC retiree program, failure to enroll in Original Medicare will result in a gap in coverage since Advantage 65/Med Comp will not pay any benefit for services that would have been covered by Medicare had the participant been enrolled. Usually, the question is whether to enroll in Part B since there is a premium for that coverage. For most individuals, there is no cost for Medicare Part A. The following enrollment rules generally apply to Part B, but beneficiaries enrolled in the retiree group should always ensure that enrollment for both A and B are completed.

Enrollment in Original Medicare
Most individuals are eligible for Medicare on the first of the month in which they turn age 65. (If their date of birth is the first of the month, eligibility is the first of the prior month.) A beneficiary who is eligible due to age has a seven-month Initial Enrollment Period (IEP) that starts three months before the month of eligibility, includes the month of eligibility and three months after. Participants in the retiree group (Enrollees and covered family members) who become eligible for Medicare and wish to stay in the TLC program must enroll in Parts A and B to effectively use the available supplemental benefits. Failure to do so will result in a gap in coverage since Advantage 65/Med Comp will not pay for any services that would have been covered by Medicare had the beneficiary been properly enrolled.

If a new retiree was already eligible for Medicare prior to their retirement date and declined coverage in Medicare Part B because they were covered based on current employment, they must enroll in Original Medicare upon retirement. If Medicare was properly declined based on coverage due to current employment, and the coverage was uninterrupted, the beneficiary can exercise a Special Enrollment Period (SEP) at any time they continue to be covered based on current employment or within the eight months after that coverage ends. If a beneficiary fails to exercise those enrollment rights, they will have to wait until the annual General Enrollment Period (GEP) that occurs each January through March, but coverage will not begin until the following July. Also, a break between coverage based on current employment and Medicare enrollment can result in a late enrollment penalty that can increase the Part B premium forever (or until eligibility due to age if later than original enrollment).

In any case, retirees should be sure to contact the Social Security Administration (800-772-1213) well in advance of the date they wish to be enrolled in Medicare. Waiting until the end of the IEP or SEP can result in a delayed enrollment and a gap in primary coverage.

Finally, if a beneficiary declines enrollment during their IEP, they may not exercise a SEP until the end of the original IEP. Also, a delay in coverage start dates during the last months of the IEP can result in a gap in primary coverage. Beneficiaries should be careful in declining Medicare coverage during the

IEP if retirement is being considered. The TLC program will not allow coverage in a non-Medicare plan if a retiree fails to exercise an enrollment opportunity that ensures Medicare coverage coincident with their retirement date.

Medicare Eligibility Due to Disability/End Stage Renal Disease (ESRD)
Eligibility for Medicare can occur prior to age 65 based on Disability. Regardless of the reason for Medicare eligibility, retiree group participants, including their covered family members, must enroll in a Medicare-coordinating plan immediately upon eligibility for Medicare if they wish to remain in the state program. This is because Medicare should become the primary payer when coverage in a large group health plan is no longer based on current employment. It is to the advantage of the Enrollee to notify the retiree program immediately upon Medicare eligibility. If the Enrollee fails to do so, the TLC program will eventually be notified of Medicare eligibility through our data sharing agreement with Medicare. If it is determined that Medicare should have been the primary payer, the TLC program will retract primary payments made in error, and the beneficiary will need to file for primary claim payments with Medicare retroactively. DHRM contracts with a vendor to assist with recovery of overpayments and, if eligibility is due to disability, with Medicare Part B enrollments.

Medicare beneficiaries may terminate active employee coverage within 60 days of Medicare entitlement or reject employer plan coverage in which case they may retain Medicare as their primary coverage. When Medicare is primary payer, employers cannot offer such active employees or their dependents secondary coverage for items and services covered by Medicare. Employers may not sponsor or contribute to individual Medigap or Medicare Supplement policies for beneficiaries who have coverage based on current employment status.

The TLC program tracks these coordination periods to ensure that the program is not paying for claims that should be absorbed by Medicare as primary payer. See Section 2.6 Retiree Health Benefits for more information on End State Renal Disease (ESRD) and benefits coordination.

Medicare Part D – No Coverage Available
Prescription drug coverage is not available in any of the Medicare-eligible plans. Retirees participating in one of the Medicare coordinating plans who desire prescription drug coverage must enroll in Medicare Part D outside of the TLC Health Benefits Plan.

Premium Costs
Employers are encouraged to contribute toward the cost of retiree coverage, but they are not required to contribute.

Early Retirees: see the Retiree Coverage Funding Options section of this manual.

Medicare Eligible Retirees: The rates for the Medicare-Coordinating Plans are pooled across all TLC groups.

If your group has elected direct bill for retiree participants, these members will receive their premium billing statements directly from the Plan Administrator. See the Direct Bill Members section of this manual for more information on Direct Billing.

The billing agents are as follows:

Plan	**Billing Agent**
TLC Key Advantage Plans & TLC HDHP	Anthem Blue Cross and Blue Shield
Sentara Vantage HMO	Sentara Health
Kaiser Permanente	Kaiser Permanente
Medicare Coordinating Plans	Anthem Blue Cross and Blue Shield

Premiums are subject to change at the beginning of each plan year. Non- Medicare plans run on the fiscal year (July 1 through June 30), while the Medicare plans run on the calendar to coordinate with Medicare.

Disability Retirements
Disability retirees must enroll in retiree coverage within 31 days of losing coverage as an active employee or, if the disability retirement has not been approved, within 31 days of the date of the disability retirement notification letter. In the case of a retroactive disability retirement approval, the retiree can enroll retroactively to the date of the disability retirement approval, not to exceed 12 months for any statewide self-funded plans or two months for any insured plan. As an alternative, the retiree can enroll prospectively, effective the first of the month after the date of the notification letter. These enrollment opportunities would apply whether or not coverage was maintained during any break while waiting for disability retirement approval.

TLC Tip: Waiving or terminating coverage in the retiree health benefits plans

- 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 TLC should sign the waiver portion of the Enrollment Form.

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

- Employees eligible for Medicare may waive TLC coverage. However, the employer may not subsidize any other plan for the employee.

Local Administrative Manual

Section 3 Enrolling or Changing Coverage

Enrolling or Changing Coverage

Section 3.1: Summary of Enrollment Deadlines

When members can request enrollment or election changes
The Local Choice Health Benefits Program (TLC) uses the most liberal eligibility and enrollment rules allowed by the IRS.

Initial Enrollment:

- **As Employee:** The request to enroll must be received within 30 days of when employment begins or the employee becomes newly eligible for coverage. When the request is received by the deadline, the coverage takes effect the first of the month coinciding with or following the date of employment or the completion of any waiting period. If the deadline is missed, the employee must wait for Open Enrollment or another qualifying mid-year event, whichever comes first.

- **As Retiree:** The request to enroll must be received within 31 days of retirement. When the request is received by the deadline, the coverage takes effect the day after the employee coverage ends.

- **As Survivor of a Retiree:** TLC requires that the request to enroll be received within 60 days of the death. If the employer's plan document calls for a more restrictive timeframe, the survivor must comply with that document. When the request is received by the deadline, the coverage takes effect the first of the month coinciding with or following the death.

- **As Extended Coverage/COBRA Qualified Beneficiary:** Inspira Financial Health, Inc. is the COBRA Administrator for the Commonwealth of Virginia State and Local Health Benefits Program. Qualified beneficiaries enrolled in TLC Extended Coverage/COBRA have available to them the same coverage and the same opportunities to make changes in their coverage as those who are not receiving Extended Coverage/COBRA.

Open Enrollment:
Open Enrollment occurs each year and is set by the Department of Human Resource Management (DHRM). It is the annual opportunity to request enrollment or make election changes (see the Open Enrollment section of this manual).

Qualifying Mid-Year Event:
With supporting documentation, certain events during the plan year permit enrollment or election changes (see the General Instructions When there is a Qualifying Mid-Year Event section of this manual).

Summary of Enrollment Deadlines

The following chart summarizes the deadlines for applying for coverage or making changes in membership.

If You Apply	Coverage Becomes Effective
Within 30 days of employment	If the enrollment action is received within the 30-calendar day timeframe, coverage will be effective the first of the month coinciding with or following the date of employment. However, if the employee's start date is the first calendar 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 (as set by DHRM)	The beginning of the group's plan year, July 1st or October 1st (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 or the event date, whichever is the later date. With birth or adoption, coverage is effective on the first of the month of the event. If the addition of a dependent causes a change in membership type the additional premium must be retroactively collected.

If the 30-day enrollment deadline is missed, an employee must experience a new Qualifying Mid-Year Event (QME) or wait until Open Enrollment before they can enroll themselves or eligible dependents in the plan. Enrollments due to a QME must be consistent and on account of the event.

Newly Eligible Employees with Other Health Benefits Coverage

Sometimes a newly eligible employee is provided continued health benefits by a previous employer for a limited period of time. The new employee may waive TLC coverage initially and postpone enrollment in the TLC Health Benefits Program until the other coverage terminates. 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. This is considered a Special Enrollment under HIPAA. For additional information on HIPAA Special Enrollments, please refer to the manual section on Qualifying Midyear Events.

Enrolling or Changing Coverage

Section 3.2: Initial Enrollment for Newly Eligible Employees

Ensuring a successful initial enrollment for a newly eligible employee is the first important step in administering health benefits.

It is the Group Benefits Administrator's responsibility to see that each newly eligible employee receives complete and timely health benefits information. This generally means distributing printed materials, but could also mean conducting benefit orientation sessions, meeting with newly eligible employees as soon as possible so they can meet enrollment deadlines, and helping an employee complete an Enrollment Form.

The timeliness of completing the enrollment process is also critical. Enrollment deadlines are described below.

Newly Eligible Employee Enrollment Procedures

1. **Newly eligible employees must enroll within 30 days of gaining eligibility**
   Newly eligible employees (new hires) have up to 30 calendar days to enroll in the health plan offered through The Local Choice Health Benefits Program (TLC). The 30-day countdown period begins on the first day of employment and ends 30 days later. If the enrollment action is received within the 30 calendar day time frame, coverage will be effective the first of the month coinciding with or following the date of employment.

   Example:
   - Employee is hired on February 10 and the employer group receives the enrollment action on February 18. Coverage is effective March 1.
   - Employee is hired on February 10 and the employer group receives the enrollment action on March 5. Coverage is effective on March 1.
   - If employment begins on February 1 and the enrollment action is received within 30 days of the employment date, the coverage is effective February 1.

   There is no discretion allowed in this area. Coverage will always be effective as described above. In no case will coverage begin before the eligible employee's first day of employment.

   Note: A probationary or waiting period before the Effective Date may be applied if uniform for all employees. Waiting periods may not exceed 59 days.

2. **If the employee does not enroll during the initial 30-day period:**
   If the employee does not enroll within the first 30 days of becoming eligible, they will not have coverage and may enroll only:
   - During the annual open enrollment period, or

- If the employee experiences a consistent qualifying midyear event and applies within 60-days of the event.

3. **Newly Eligible Employees with Other Health Benefits Coverage**
   Sometimes a newly eligible employee is provided continued health benefits by a previous employer for a limited period of time. The new employee may waive TLC coverage initially and postpone enrollment in the TLC Health Benefits Program until the other coverage terminates. This is considered a Special Enrollment under HIPAA. For additional information see the HIPAA Special Enrollments section of this manual.

4. **Newly Eligible Employees with Adult Incapacitated Children over Age 26**
   If a newly eligible employee wishes to enroll an incapacitated child over age 26 in the health care plan, all of the following conditions must be met:

   - the enrollment form is submitted within 30 days of hire;
   - the child has been covered continuously as an incapacitated dependent on a parent's group employer coverage since the incapacitation first occurred or as a Medicaid/Medicare recipient (Note: supporting documentation must be submitted);
   - the incapacitation commenced prior to the child attaining the limiting age of 26;
   - 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 financial self-support. This extension of coverage must be approved by your health plan; and
   - other medical certification and eligibility documentation is provided as needed.

5. **Newly Eligible Employees - During and After Open Enrollment**
   Employees who become eligible for the program during or after Open Enrollment have the option to make two plan elections for health benefits.

   Employees with an eligibility begin date of May 1 (August 1 for certain school groups) can make:
   - An election for coverage effective May 1 (August 1 for certain school groups), and/or
   - An election by the end of Open Enrollment for coverage effective July 1 (October 1 for certain school groups).

   Employees with an eligibility begin date of June 1 (September 1 for certain school groups) can make:
   - An election for coverage effective June 1 (September 1 for certain school groups), and/or
   - An election, within the 30-day enrollment period, for coverage effective July 1 (October 1 for certain school groups).

Steps to Enroll Newly Eligible Employees:
When a newly eligible employee wants to enroll in health benefits, as a Benefits Administrator, you will need to take the following steps:

1. Ensure that the employee is newly eligible for benefits according to your group's definition of eligible employees.

2. Inform the eligible employee that he has 30 days from the date of employment to enroll single, dual or family membership (except in the case where other employee benefits are providing continued coverage for a limited period of time). Be sure to help the employee understand which of his dependents are eligible for coverage. Advise the employee of the limitations on eligibility for dependents and the penalty that will be imposed if the employee is found covering an ineligible dependent. The TLC web site provides detailed eligibility information.

Treat both former employees, with more than a 30-day break in service, and those returning from leave without pay with more than a 30-day break in coverage as new employees and offer the complete menu of enrollment options.

Give the employee complete information about the health benefits plans and types of membership. You may direct them to the appropriate plan administrators web site for the most current information regarding the TLC Health Benefits Program.

3. 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 on a pre-tax basis and that premiums are deducted in advance of the month of coverage.

4. Assist the employee in completing the Enrollment Form.
   a. Inform the employee about eligibility criteria for dependents
   b. Make sure the employee completes Parts 1-4 of the Enrollment Form
   c. Ask the employee to make sure Social Security numbers are correctly listed for their covered spouse and/or dependents. Employees can only cover a person as dependent if that person is a U.S. citizen, U.S. resident alien, U.S. national, or a resident of Canada or Mexico. When required, employees must provide the documentation from the appropriate federal agency validating the dependent's entry into the country.

6. Before submitting the Enrollment Form, check to see that the employee filled in the form completely and accurately.

   If a spouse and/or dependents are covered, you must obtain the required eligibility documentation based on the dependent's relationship.

7. Tell the employee when coverage will begin in accordance.

8. Advise employees enrolling in an HMO to select a PCP by calling the HMO directly, submitting a PCP Selection Form to the HMO, or by sending a letter by fax or mail to the HMO.

9. Tell the employee that the health benefits plan will mail ID cards to his or her home address. The employee may check with the plan if the ID cards are delayed or if they note an error on the cards.

   Questions regarding the ID card should be directed to:
   - Anthem BCBS Key Advantage and TLC HDHP Plans: 800.552.2682
   - Kaiser HMO Plan: 800.777.7902
   - Sentara Health Vantage HMO: 866.846.2682

   Key Advantage and TLC HDHP members may also request additional ID cards through the Sydney Mobile Health app or by calling 866.857.6713. ID cards are typically received no earlier than a week before the effective date.

10. Advise the employee that they must provide coordination of benefits information each year to the appropriate plan administrator to ensure proper claim payments.

11. Once an employee has submitted an Enrollment Form within 30 days of becoming eligible, that election is binding and may not change after it takes effect until the next annual open enrollment period, unless the employee experiences a consistent Qualifying Mid-Year Event.

12. Make sure the employee receives a copy of the appropriate member handbook and other information describing the coverage. Current copies of the member handbooks and amendments may be downloaded from the TLC website at www.thelocalchoice.virginia.gov.

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

14. Submit the Enrollment Form adding the employee to your health benefits plan and keep a copy for your files. You may also fax the Enrollment Form to DHRM at 804.786.1708.

15. If the employee does not want to enroll in The Local Choice Health Benefits Program, have them complete Part 4A: Health Care Coverage Election Request section of the Enrollment Form and keep the original for your files. A copy of the waiver should be sent to TLC.

If an Enrollment Form is not obtained, document your effort and maintain a copy of the letter sent to the employee that states they do not have coverage in the health plan.

Adding Family Members to an Existing Family Contract
An otherwise eligible family member may be added to an existing family contract prospectively at any time. This means that the effective date for coverage will be the first of the month following the date the employee or retiree submits the request but never earlier than the date that the family member became eligible. This flexibility is unique to family memberships. There is an exception to the prospective effective date rule. If a family membership already exists, a newborn or newly-adopted child (including a pre-adoptive agreement approved by DHRM), can be added at any time retroactive to the date of birth or adoption, not to exceed 12 months.

Enrolling or Changing Coverage

Section 3.3: Changing Type of Membership

Reducing Membership

It is the employee's responsibility to submit to their Group Benefits Administrator a completed Enrollment Form to reduce health benefits membership when a previously eligible dependent loses eligibility due to contractual provisions in the plan. Coverage terminations, reductions in membership or waiver of coverage can be made the first of the month following a Qualifying Mid-Year Event.

Notification of the change must be made within 60 days of the event.

Enrolling or Changing Coverage

Section 3.4: Ending a Member's Coverage

Waiving Coverage
For the purpose of this section, waiving coverage means to completely terminate membership for the policyholder and all covered family members, not just to reduce membership.

For active employees, waiving coverage is limited to:
- Open Enrollment
- Qualifying midyear events that are consistent with waiving coverage
- Loss of eligibility events

Retiree group participants may waive coverage prospectively at any time. However, if the retiree or survivor waives his or her own coverage, they may not return to the program at any time. The only exception is if they waive to become covered as a family member under the active employee program and maintain continuous coverage until that eligibility is lost. In that case, they may resume coverage in the retiree program as long as there is no break in state program coverage.

To waive coverage, the member must complete the Enrollment Form. The Local Employer Group should keep the supporting documentation for their records. After coverage is waived, the employer should send a letter stating the date coverage will end. A copy of the Enrollment Form waiving coverage should be sent to TLC at the address on the form.

Note: For ACA reporting purposes, when an employee who has previously waived coverage in the health plan becomes ineligible for the health benefits plan and/or terminates employment, a Group Adjustment Form must be submitted to TLC.

Canceling Coverage
It's important to let TLC know immediately when coverage should be ended for a member of your group.

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 things such as a divorce, termination of employment or a dependent child losing coverage.

An employee may cancel coverage at Open Enrollment or with a Qualifying Mid-Year Event that is consistent with cancellation of coverage. Coverage terminates at the end of the month in which the qualifying event occurs or at the end of the month preceding your Open Enrollment effective date.

When an employee's coverage is terminated, the coverage for their spouse and child(ren), if any, also ends.

NOTE: If a terminated employee returns to work for the same local employer group with a break in service that is less than 30 days, the employee can be re-enrolled in the health plan without a break in coverage. No change in plan or coverage level is permitted.

Local Administrative Manual

Section 4 Personal Changes

Personal Changes

Section 4.1: General Instructions: When There Is a Qualifying Event

What are Qualifying Mid-Year Events/Life Events (QMEs)?
In general, cafeteria plan elections are irrevocable for the duration of the plan year. However, QMEs are specific life events that allow health plan participants to make mid-year election changes. Because cafeteria plans allow for pre-tax premium contributions, these events are limited to those defined by the Internal Revenue Service (IRS). However, while cafeteria plans may not allow election changes that are not allowed by the IRS, they may further limit those IRS events within their specific plan provisions. The Local Choice Health Benefits Program (TLC) allows changes based on all QMEs defined by the IRS.

NOTE: While retiree group participants do not pay their premiums on a pre-tax basis, for consistency purposes and to protect the plans from adverse selection, they are held to the same QME rules as active employees.

To exercise mid-year election changes based on Life Events (QMEs), enrollees/subscribers (not covered family members) must submit the change request within the time permitted for a QME event within your employer group. With the exception of certain HIPAA Special Enrollments and all loss of eligibility events, addressed later in this section, the election change will be effective the first of the month after the notification/request is submitted.

The countdown for the QME notification period begins on the day of the qualifying event. Failure to make the request within the window will result in loss of the right to make the midyear election change and delaying the change until open enrollment. However, once the election change takes effect, it is binding and cannot be changed until open enrollment or upon the occurrence of another consistent qualifying event.

Failure to remove ineligible persons
An employee's failure to remove ineligible persons from their health benefits membership can result in the retraction of claims, loss of future eligibility 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 60 days of the dependent's loss of eligibility, during open enrollment or with another consistent QME.

Personal Changes

Section 4.2: Birth, Adoption or Placement for Adoption

Life Event /Qualifying Mid-Yer Event (QME) – Birth, Adoption, or Placement for Adoption
This life event/qualifying mid-year event (QME) election change is permitted to add newborn/ child(ren) due to birth, adoption or placement for adoption, provided the election change requested is on account of and corresponds with the event.

The employee is permitted to do the following:

- enroll or change the health plan.
- add legal spouse and eligible family members (tag-along dependents).
- waive coverage or remove family members if enrolled under the spouse's health plan.

What documentation is required?
Documentation validating the birth, adoption or placement of adoption such as official birth certificate/hospital birth record or court order documenting the adoption or placement). The countdown begins on the day of the birth event. If documentation is not available, do not miss the enrollment deadline. There is an additional 60-days from the election request to submit all supporting documentation.

Health care coverage will not be effective until approved documentation is received.

How to submit the request.
Starting with the date of the birth, adoption or placement of adoption event, there is 60 calendar days to use Cardinal HCM or complete a paper Enrollment Form and submit to the agency's Benefits Administrator.

When approved changes take effect.
The Health Insurance Portability and Accountability Act (HIPAA) Special Enrollment provisions for birth, adoption or placement for adoption allows an exception to the prospective effective date that applies to most life events/qualifying mid-year events (QME). Election changes to health plan coverage for newborns, adopted child(ren), and those children placed for adoption will be retroactive to the date of birth, adoption or placement for adoption. Again, this retroactive effective date is an exception to the prospective effective date with most other events.

When making health plan changes and adding eligible dependents or newly eligible family members for birth, adoption or placement of adoption, those changes are effective the first of the month of the birth.

For all health plan changes due to birth, adoption or placement for adoption, the new premiums are due for the full month of coverage.

Due to a possible membership increase, adding a child to coverage may result in a premium increase. However, if family membership already exists, the premium will not increase, and the child can be added at any time retroactive to the date of birth or adoption, not to exceed 12 months.

Reminder: Adding other eligible family members/dependents to existing family membership can be added prospectively at any time (tag-along rule). See Adding Family Members to an Existing Family Contract for more information.

Pre-Adoptive Agreements
A pre-adoptive agreement is a document that states an authoritative body (such as a 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.

Children who are placed for adoption under a private arrangement will not be deemed eligible for coverage under a state 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, which must review all related documents and authorize the enrollment of the child before coverage is effective.

Like a birth event, 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 determining eligibility) will be eligible for coverage retroactive to the date of adoption or placement for adoption in which the adoption is finalized or the pre-adoptive agreement is approved by DHRM (assuming timely enrollment within the 60-day window).

Other Allowed Changes
Under HIPAA, employees may enroll themselves, their legal spouse, and the newly-acquired dependent based on the event. The IRS cafeteria plan rules also allow other eligible family members/dependents to "tag-along" with the enrollment.

IMPORTANT: HIPAA also allows a plan change based on this event. However, participants who have existing coverage and exercise their right to make a plan change due to this event should carefully consider the difference in health plan coverage that will generally apply to covered family members on the effective date of the new coverage.

In the case of a newborn, this could mean that the claims related to the birth may have different out-of-pocket costs or network provider participation.

Note: Health care coverage changes will not be effective until approved documentation is received.

Personal Changes

Section 4.3: Death of Covered Family Member

Life Event or Qualifying Mid-Year Event (QME) - Death of Covered Family Member

This life event/qualifying mid-year event (QME) election change is permitted when a covered family member under the health plan dies, **provided the election change requested is *on account of and corresponds with* the event.**

Employee Permitted Changes:

If Spouse
- Remove only deceased spouse and stepchildren.
- May enroll or change the health plan.
- May add eligible family members who lost their coverage due to the death of the spouse.

If Dependent Child
- Remove only deceased dependent child.

1. ***What documentation is required?*** Documentation validating the death (newspaper article, obituary, death certificate). If requesting a plan change, documentation of the coverage under the other health plan is required to ensure consistency.

2. ***How to submit the request.*** Within 60-days of the family member's death, use Cardinal HCM or complete a paper Enrollment Form and submit to the agency's Group Benefits Administrator.

3. ***When approved changes take effect.***
   a. **Health care coverage:** Changes are effective the first of the month following the family member's death.
   b. ***Election changes are irrevocable once the effective date of the change has occurred.***

The death should be reported to the appropriate Local Employer's Benefits Administrator within 60 days of the event and is consistent with terminating coverage for the deceased family member at the end of the month in which the death occurs.

If this results in a reduction in membership level, the premium will be reduced accordingly. Documentation of the death (newspaper article, obituary, death certificate) should be obtained, but a death certificate is not required.

If the death is not reported within the 60-day Life-Event/QME window, termination of the family member's coverage will still be allowed due to the clear and convincing error (as defined by the IRS), and the family member will be dropped from coverage effective on the last day of the month in which the death occurred. Any resulting change in membership

level will be allowed once the error is discovered, and any premium overpayment will be returned to the local employer for the period of erroneous coverage, ***not to exceed retroactivity back to the first of the calendar year during which the error is identified***.

If stepchildren are covered on the policy, and the death of the family member results in stepchildren no longer being eligible for coverage. **The stepchildren must be removed along with the deceased family member a**s the stepchildren become ineligible at the end of the month of the spouses' death. Stepchildren removed from the policy become eligible for COBRA/Extended Coverage due to "loss of dependent eligibility" see *COBRA/Extended Coverage section for more information*.

In the case of **Retirees**, who pay their full premium with after-tax dollars, a refund of premium overpayments may be made up to 12 months prior to discovering failure to timely report the family member's death.

Decentralized TLC Groups
See Cardinal HCM at www.cardinalproject.virginia.gov and the Benefit Event Detail page for keying instructions, benefit class codes, etc. with additional details on processing this benefit event. Please adhere to processing guidelines to ensure transactions are submitted to the vendors appropriately.

Personal Changes

Section 4.4: Divorce

Life Event- Qualifying Mid-Year Event (QME) – Divorce

Divorce is an event that results in loss of eligibility for the ex-spouse and stepchildren of the employee or retiree through whom their eligibility was gained. It is a qualifying event that is consistent with a reduction in membership if dropping the spouse and stepchildren, as applicable, reduces the remaining covered family members to a lower membership level. Coverage will be lost for the affected family members effective at the end of the month in which the divorce is final. **Failure of an employee or retiree to remove an ineligible person from the state program may result in suspension from the program for up to three years.** Divorce does not allow termination of coverage for any family members who do not lose eligibility due to the event.

NOTE: Separation, even with a property settlement, is not a Qualifying Event and will not allow for dropping a spouse or stepchild's coverage outside of open enrollment.

An enrollment form must be submitted to the Group Benefits Administrator. If the divorce results in a change in membership, the premium will be reduced the first of the month following the date of the final divorce decree if the notification/request is made timely of the event. The effective date of the loss of coverage will be the end of the month during which the final decree is issued (not prospective to the notification) based on the loss of eligibility date.

If the employee does not make timely notification of the divorce (within the time permitted by the employer group for a QME) coverage lost consistent with the event will still be terminated at the end of the month in which the final divorce decree is issued, but the employee will not be allowed to reduce membership until the next Open Enrollment or other consistent qualifying mid-year event, whichever occurs first. At the discretion of DHRM, some exceptions may apply to Retiree Group participants.

The agency Group Benefits Administrator should obtain a copy of the final divorce decree from the employee to document the date of the divorce.

This Qualifying Life Event election change is permitted when an employee becomes divorced, **provided the election change requested is *on account of and corresponds with* the event.**

Health Insurance Coverage:

- Remove only ex-spouse and stepchildren.
- May enroll or change the plan.
- May add eligible family members who lost their coverage due to the divorce.

Personal Changes

Section 4.5: Employment Changes

Life Event or Qualifying Mid-Year Event (QME) – Employment Changes

This section discusses the following employment changes:

- Beginning a Leave Without Pay
- Full-Time to Part-Time
- Part-Time Classified/Faculty to Full-Time
- Return from a Leave Without Pay

Beginning a Leave without Pay (LOA)
These Qualifying Life Event election changes are permitted when you begin an unpaid leave of absence (LWOP) and lose the agency's contribution to your health care. **Election changes must be *on account of and correspond with* the event.** If the LWOP is less than 30 days, you will be enrolled in the same elections that were in effect at the beginning of the leave.

- The employee may waive coverage.
- The employee may remove eligible family members.
- The employee may continue to have coverage as long as they make arrangements with their local employer for payment of the premiums while on unpaid leave.

Note: The employee and any removed family members will receive an Extended Coverage Election Notice (COBRA).

1. ***What documentation is required?*** None. The local employer will validate the employment status change.

2. ***How to submit the request.*** Starting with the last day of coverage, the employee must submit the change request within the time permitted for a QME event within your local employer group.

3. ***When approved changes take effect.*** Changes are effective the first of the month following receipt of the request or following the event, whichever is later. When the later date is the first of the month, changes are effective that day. Changes are irrevocable once the effective date of the change has occurred.

Reminder: If the employee should miss this opportunity to submit a change request, the next chance will be at Open Enrollment
or with another consistent Qualifying Life Event, whichever comes first.

Full-time to Part-time
These Qualifying Life Event election changes are permitted when you change from full-time employment to a part-time employment status that does not provide the employer contribution to the health insurance premium, **provided the election change requested is *on account of and***

***corresponds with* the event.** Your full-time, active healthcare coverage automatically terminates at the end of the month that you cease to be full-time if the local employer does not contribute to the premium for part-time employees. The employee and removed family members will receive an Extended Coverage Election Notice (COBRA).

- The employee may enroll in part-time active health coverage if offered by the local employer.
- The employee may enroll any eligible family members previously covered on their full-time active coverage.

1. **What Documentation is required?** None. The local employer group will validate the change in employment status.

2. ***How to submit the request.*** Starting with the date the employee becomes eligible to enroll in part-time health insurance (if offered by your local employer group), the employee must submit the change request within the time permitted for a QME event within your local employer group.

3. ***When approved changes take effect.*** Changes are effective the first of the month following receipt of the request or following the event, whichever is later. When the later date is the first of the month, changes are effective that day.

Reminder: Active coverage ends at the end of the month in which the employment status changes. The employee must take action to enroll in coverage as a part-time employee. If they miss this opportunity to submit an election change request, the next chance will be at Open Enrollment or with another consistent Qualifying Life Event, whichever comes first.

Part-time to Full-time
These qualifying mid-year event election changes are permitted when the employee changes from a part-time employment status that does not provide the employer contribution to the health insurance premium to full-time employment, **provided the election change requested is *on account of and corresponds with* the event.**

- The employee may enroll or change the plan (if applicable).
- The employee may add eligible family members.

1. ***What documentation is required? The local employer*** will validate your employment status. If adding dependents, the employee must provide documentation of their eligibility for the TLC health plan.

2. ***How to submit the request.*** Starting with the last day of the part-time employment status, the employee must submit the change request within the time permitted for a QME event within your local employer group.

3. ***When approved changes take effect.*** Changes are effective the first of the month following receipt of your request or following the event, whichever is later. When the later date is the first of the month, changes are effective that day.

Reminder: Active coverage ends at the end of the month in which the employment status changes. The employee must take action to enroll in coverage as a part-time employee. If they miss this opportunity to submit an election change request, the next chance will be at Open Enrollment or with another consistent Qualifying Life Event, whichever comes first.

Return from a Leave of Absence without Pay
These qualifying mid-year event election changes are permitted if the employee waived coverage or changed thier elections upon taking an unpaid leave of absence which was **30 days or more** and they are now returning to work. Election changes must be *on account of and correspond with* the event. If the employee returns from an unpaid leave of absence in less than 30 days, they must re-enroll in the same elections you had prior to the leave.

- The employee may enroll or change the plan (if applicable).
- The employee may add eligible family member.

1. ***What documentation is required? None. The local employer*** will validate the employment status. If adding dependents, the employee must provide documentation of their eligibility for the health plan.

   If requesting a plan change, documentation of the coverage under the other plan is required to ensure consistency.

2. ***How to submit the request.*** Starting with the day of return to work, the employee must submit the change request within the time permitted for a QME event within your local employer group.

3. ***When approved changes take effect.*** Changes are effective the first of the month following receipt of your request or following the event, whichever is later. When the later date is the first of the month, changes are effective that day. Election changes are irrevocable once the effective date of the change has occurred.

Personal Changes

Section 4.6: Enrollment in Qualified Health Plan Through the Exchange (Marketplace)

Life Event or Qualifying Mid-Year Event (QME) – Enrollment in Marketplace

This life event/qualifying mid-year event (QME) election change is permitted when you enroll in Marketplace coverage under the Affordable Care Act (ACA), **provided the election change requested is *on account of and corresponds with* the event.**

- The employee is permitted to waive (revoke) their enrollment in the employer group health plan coverage when enrolling in Marketplace coverage under the ACA.
- The enrolled dependent is permitted to terminate their enrollment in the employer group health plan coverage when enrolling in Marketplace coverage under the Affordable Care Act (ACA).
- Membership changes are allowed based on this event.

1. ***What documentation is required?*** Documentation of the Marketplace coverage enrollment and the effective date. The countdown begins on the day of the event. *If documentation is not available, do not miss the enrollment deadline. There is an additional 60-days from the election request to submit all supporting documentation.*

   Health care coverage will not be effective until approved documentation is received.

2. ***How to submit the request.*** Starting with the date of enrollment in Marketplace coverage or the date the Marketplace coverage begins, whichever is later, the employee must submit the change request within the time permitted for a QME event within your local employer group.

3. ***When approved changes take effect.*** Changes are effective the first of the month following the receipt of the request or the day the Marketplace coverage begins, whichever is later. As long as the request is submitted within the 60-day enrollment window. When the later date is the first of the month, changes are effective that day.

   Election changes are irrevocable once the effective date of the change has occurred.

Reminder: If this enrollment opportunity is missed, the next chance will be at Open Enrollment or with another consistent life event/qualifying mid-year event (QME), whichever comes first

Personal Changes

Section 4.7: Gain or Loss of Eligibility for Medicare or Medicaid

Life Event or Qualifying Mid-Year Event (QME) – Gain or Loss of Eligibility for Medicare or Medicaid

***Gained* Eligibility under Medicare or Medicaid**
These qualifying mid-year event election changes are permitted when the employee, spouse, or child enrolls in Medicare or Medicaid (other than coverage solely for pediatric vaccines). These changes are voluntary; No changes to the TLC health plans are required when an active employee or a covered dependent of an active employee becomes eligible for Medicare* or Medicaid.

*Retiree group participants or their covered family members who are eligible for Medicare must enroll in a Medicare Coordinating plan unless they are still in their coordination period for End Stage Renal Disease. ****if the Medicare plan is offered by the locality****

- The employee may waive TLC coverage when he/she is eligible for Medicare or Medicaid.
- The employee may remove family members enrolling in Medicare or Medicaid.
- The employee may change the plan when removing the named individual(s) enrolling in Medicare or Medicaid.

1. **What documentation is required.** Documentation from Medicare or Medicaid validating enrollment.

2. **How to submit the request.** Starting with the first day covered under Medicare or Medicaid, the employee must submit the change request within the time permitted for a QME event within your local employer group.

3. **When approved changes take effect.** Changes are effective the first of the month following receipt of your request or following the event, whichever is later. When the later date is the first of the month, changes are effective that day. Election changes are irrevocable once the effective date of the change has occurred.

Reminder: If the employee should miss this opportunity to submit a change request, the next chance will be at Open Enrollment or with another consistent Qualifying Mid-Year Event, whichever comes first.

***Lost* Eligibility under Medicare or Medicaid**
These qualifying mid-year event election changes are permitted when the employee, spouse, or child loses eligibility for Medicare or Medicaid.

- The employee may enroll.
- The employee may add eligible family members.
- The employee may change the plan when adding eligible family members.

1. **What documentation is required.** Documentation from Medicare or Medicaid validating the loss of coverage. If adding dependents, the employee must provide documentation that they are eligible for the TLC plan.

2. **How to submit the request.** Starting with the last day covered under Medicare or Medicaid, the employee must submit the change request within the time permitted for a QME event within your local employer group.

3. **When approved changes take effect.** Changes are effective the first of the month following receipt of your request or following the event, whichever is later. When the later date is the first of the month, changes are effective that day.

Reminder: If the employee should miss this opportunity to submit a change request, the next chance will be at Open Enrollment or with another consistent Qualifying Mid-Year Event, whichever comes first.

Personal Changes

Section 4.8: HIPAA Special Enrollments

Life Event or Qualifying Mid-Year Event (QME)- HIPAA Special Enrollments

This section includes the following information:

- HIPAA Special Enrollments – General
- HIPAA Special Enrollments – Loss of Other Coverage

These qualifying mid-year event health insurance election changes are permitted when the employee experiences a Qualifying Midyear Event (QME) that is recognized as a HIPAA Special Enrollment event. These events are exempt from the consistency rule for health insurance coverage.

These events include:

- Marriage
- Birth, Adoption, or Placement for Adoption
- Loss of other coverage
- Loss of eligibility under Medicaid or CHIP
- Gaining eligibility for premium assistance from Medicaid or CHIP

These events allow the employee to:

- enroll in health coverage;
- add eligible family members; and/or
- change health plan.

Reminder: If employee should miss this opportunity to submit a change request, the next chance will be at Open Enrollment or with another consistent Qualifying Mid-Year Event (QME), whichever comes first.

HIPAA Special Enrollments -Loss of other coverage

These Qualifying Mid-Year Event (QME) election changes are permitted when the employee, spouse, or child lose eligibility for other group health care coverage, including Medicaid or State Children Health Insurance Program (CHIP). The other coverage may include exhausted COBRA coverage, or non-COBRA coverage where (a) you are no longer eligible, or (b) the employer's contribution toward the premium ceases. This would also include Special Enrollment for Individuals who become Eligible for a State Premium Assistance Subsidy from Medicaid or State Children Health Insurance Program (CHIP).

- The employee may enroll in health coverage;
- Add eligible family members; and/or
- Change health plan.

1. ***What documentation is required*** A copy of the HIPAA Certificate of Creditable Coverage or other documentation validating the loss of other employer group coverage for governmental coverage.

2. ***How to submit the request.*** Starting with the last day of coverage, the employee must submit the change request within the time permitted for a QME event within your local employer group.

3. ***When approved changes take effect.*** Changes are effective the first of the month following receipt of your request or following the event, whichever is later. When the later date is the first of the month, changes are effective that day. Election changes are irrevocable once the effective date of the change has occurred.

Personal Changes

Section 4.9: Judgment, Decree or Order to Add or Remove a Child

Life Event or Qualifying Mid-Year Event (QME) – Judgment, Decree or Order to Add or Remove Child

Adding A Child
These qualifying mid-year event election changes are permitted when an employee is directed by judgement, decree or order to provide coverage for a child not currently covered. This may have resulted from a divorce, a change in legal custody, including obtaining full permanent custody of an "other child," a Qualified Medical Child Support Order (QMCSO) or a National Medical Support Notice (NMSN). Election changes must be on account of and correspond with the event.

The employee can:

- Add the eligible child named in the order; and
- Make a corresponding change to the health plan

Note: If the locality is served with a QMSCO or NMSN or another state child support agency document, the change will be made as required, including enrollment in coverage if not already enrolled.

1. **What documentation is required** A copy of the document naming the child. Custody must be awarded solely to the employee. Joint custody is allowed when awarded to the employee and spouse, or the employee and the employee's minor child when both minor child parent and other child reside in the employee's home.

2. **How to submit the request.** Starting with the date notice is received to cover the child, the employee must submit the change request within the time permitted for a QME event within your local employer group.

3. **When approved changes take effect.** Approved changes are effective the first of the month following receipt of your request or following the event, whichever is later. When the later date is the first of the month, changes are effective that day. Election changes are irrevocable once the effective date of the change has occurred.

Removing a Child
These qualifying mid-year event election changes are permitted when the employee, spouse, former spouse or other individual is directed by judgement, decree or order to provide coverage for a child currently covered under your plan. This may have resulted from a divorce, a change in legal custody, or a Qualified Medical Child Support Order. Election changes must be on account of and correspond with the event.

The employee can:

- Remove the child named in the order (Cobra does not apply); and
- Make a corresponding change to the health plan.

1. **What documentation is required** A copy of the document naming the child and documentation that the other individual has enrolled the child.

2. **How to submit the request.** Starting with the date notice is received to cover the child, the employee must submit the change request within the time permitted for a QME event within your local employer group.

3. **When approved changes take effect.** Approved changes are effective the first of the month following receipt of your request or following the event, whichever is later. When the later date is the first of the month, changes are effective that day. Election changes are irrevocable once the effective date of the change has occurred.

Personal Changes

Section 4.10: Loss of Eligibility Under Governmental Plan

Life Event or Qualifying Life Event (QME) – Loss of Eligibility Under Governmental Plan

These qualifying mid-year event election changes are permitted when the employee, spouse, or child loses coverage under a group health care plan sponsored by a government entity. These include state sponsored plans for children (including FAMIS), plans offered by Indian Tribunal governments, and national plans offered by foreign governments. Election changes must be on account of and correspond with the event.

The employee can:

- Enroll in health coverage;
- Add eligible family members; and
- Change the health plan

1. **What documentation is required?** Documentation validating the loss of the government-sponsored plan coverage. If adding dependents, the employee must provide documentation that they are eligible for the TLC plan.

2. **How to submit the request.** Starting with the last day of coverage, the employee must submit the change request within the time permitted for a QME event within your local employer group.

3. **When approved changes take effect.** Changes are effective the first of the month following receipt of your request or following the event, whichever is later. When the later date is the first of the month, changes are effective that day. Election changes are irrevocable once the effective date of the change has occurred.

Reminder: If the employee should miss this opportunity to submit the change request, the next chance will be at Open Enrollment or with another consistent Qualifying Mid-Year Event, whichever comes first. If the employee is already in a family membership and need to add eligible dependents, they may add the eligible family member(s) prospectively.

Personal Changes

Section 4.11: Marriage

Life Event or Qualifying Mid-Year Event (QME) – Marriage

This life event/qualifying mid-year event (QME) election change is permitted to add a legal spouse due to marriage. Newly eligible dependents (e.g., stepchildren) may also be added as the result of the marriage, provided the election change requested is *on account of and corresponds with* the event.

The employee is permitted to:

- Enroll or change the health plan.
- Add legal spouse and eligible family members (tag-along dependents).
- Waive coverage or remove family members if enrolled under the spouse's health plan.

1. **What documentation is required?** Documentation validating the marriage (official marriage certificate). The countdown begins on the day of the marriage event. If documentation is not available, do not miss the enrollment deadline. There is an additional 60-days from the election request to submit all supporting documentation.

   Health care coverage will not be effective until approved documentation is received.

2. **How to submit the request.** Starting with the date of the marriage event, the employee must submit the change request within the time permitted for a QME event within your local employer group.

3. **When approved changes take effect.** Changes are effective the first of the month following the receipt of the request or following the marriage event, whichever is later. As long as the request is submitted within the 60-day enrollment window. When the later date is the first of the month, changes are effective that day.

Election changes are irrevocable once the effective date of the change has occurred.

Marriage is an event that creates a ***HIPAA Special Enrollment*** opportunity. This means that, as long as the notification/request is submitted timey, any eligible family member, not just the newly acquired spouse or child(ren), may be added. Documentation to support the event and eligible relationship is required when adding any family members. See the Eligible Active Employees and Family Members section for more information.

However, if the employee/retiree has an existing family membership at the time of the marriage event, additional eligible family members can be added prospectively at any time.

Personal Changes

Section 4.12: Move Affecting Eligibility for Health Plan

Life Event or Qualifying Mid-Year Event (QME) – Move Affecting Eligibility for Health Plan

These qualifying mid-year event election changes are permitted when the employee, spouse or child's eligibility for a health care plan changes due to a permanent change in in residence, including moving into and out of a plan's service area or a move into or out of the United States. Election changes must be on account of and correspond with the event.

Note: The employee cannot cover a person as a dependent unless that person is a U.S. citizen, U.S. resident alien, U.S. national, or a resident of Canada or Mexico.

The employee can:

- enroll or change your plan
- add eligible family members when they move into your plan's service area
- remove eligible family members when they move out of your plan's service area
- add eligible family members when they enter the United States with a valid Visa, proof of alien status, or other homeland security paperwork

1. **What documentation is required?** The local employer will validate the change of address. If adding dependents, the employee must provide documentation that they are eligible for the TLC plan. A valid VISA, proof of alien status, or other homeland security paperwork must be submitted for the dependents who do not have a valid SSN.

2. **How to submit the request.** Starting with the date of the permanent change in residence, the employee must submit the change request within the time permitted for a QME event within your local employer group.

3. **When approved changes take effect.** Changes are effective the first of the month following the receipt of the request or following the marriage event, whichever is later. As long as the request is submitted within the 60-day enrollment window. When the later date is the first of the month, changes are effective that day.

   Note: When a dependent leaves the country, changes in health care coverage are effective the first of the month following the loss of eligibility under the employee's plan.

   Changes are irrevocable once the effective date of the change has occurred.

Reminder: If the employee should miss this opportunity to submit a change request, the next chance will be at Open Enrollment or with another consistent Qualifying Mid-Year Event, whichever comes first. If they already have a Family membership and need to add eligible dependents, they may do so prospectively.

Personal Changes

Section 4.13: Other Employer's Open Enrollment

Life Event or Qualifying Mid-Year Event (QME) – Other Employer's Open Enrollment or Allowable Health Plan Change

This life event/qualifying mid-year event (QME) election change is permitted when the coverage for you, your spouse, or your child under an employer's health care plan is changed and a corresponding change on your plan is desired. This includes Open Enrollment under another employer's plan when the other employer's plan operates under a different plan year (not including COBRA qualified beneficiaries who are enrolled during their COBRA coverage period). **IRS rules require that election changes must be *on account of and correspond with* the event.**

The employee is permitted to:

- enroll or change your plan when a corresponding change is made under the other plan
- add eligible family members who are removed from the other plan
- remove family members who enroll in the other plan. Removed family members do not qualify for Extended Coverage (COBRA)
- may waive coverage if you are newly enrolled under the other plan

1. **What documentation is required?** Documentation from the other employer validating the corresponding change in their coverage or the change made during the Open Enrollment period. If adding dependents, the employee must provide documentation that they are eligible for the TLC health plan. *If documentation is not available, do not miss the enrollment deadline. There is an additional 60-days from the election request to submit all supporting documentation.*

   Health care coverage will not be effective until approved documentation is received.

2. **How to submit the request.** Starting with the first day covered under the other employer's plan, the employee must submit the change request within the time permitted for a QME event within your local employer group.

3. **When approved changes take effect.** Changes are effective the first of the month following the receipt of request or following the event, whichever is later. When the later date is the first of the month, changes are effective that day.

Election changes are irrevocable once the effective date of the change has occurred.

Reminder: If the employee should miss this opportunity to submit a change request, the next chance will be at Open Enrollment or with another consistent Qualifying Mid-Year Event, whichever comes first. If they already have a family membership and need to add eligible dependents, they may add the dependents prospectively.

Personal Changes

Section 4.14: Spouse's or Child's Gain or Loss of Eligibility Under Employer

Life Event or Qualifying Mid-Year Even (QME) – Spouse's or Child's Gain or Loss of Eligibility Under Employer Plan

These qualifying mid-year event election changes are permitted when the spouse or a child covered under the TLC plan changes employment status and becomes eligible for their employer's plan, provided the election change requested is on account of and corresponds with the event. This includes the spouse or child beginning employment or returning to work from an unpaid leave of absence.

The employee is permitted to:

- waive coverage if you become enrolled in the other plan;
- remove family members who become enrolled in the other plan; and
- change the plan.

Note: Removed family members do not qualify for Extended Coverage (COBRA)

1. **What documentation is required?** Documentation provided by the other employer validating enrollment under their plan or eligibility/employment change.

2. **How to submit the request.** Starting with the first day covered under the other employer's plan, the employee must submit the change request within the time permitted for a QME event within your local employer group.

3. **When approved changes take effect.** Changes are effective the first of the month following the receipt of the request or following the event, whichever is later. When the later date is the first of the month, changes are effective that day.

Reminder: If the employee should miss this opportunity to submit a change request, the next chance will be at Open Enrollment or with another consistent Qualifying Mid-Year Event, whichever comes first.

Spouse or Child Lost Eligibility under Their Employer's Plan

These qualifying mid-year event election changes are permitted when the spouse or child changes employment status and is no longer eligible for their employer's plan, provided the election change requested is on account of and corresponds with the event.

The employee can:

- enroll in plan from a waive status;
- add eligible family members; and
- change the plan.

1. **What documentation is required?** Documentation provided by the other employer validating the loss of eligibility under their plan. If adding dependents, the employee must provide documentation that the dependents are eligible for the TLC plan.

2. **How to submit the request.** Starting with the first day eligibility is lost under the other employer's plan, the employee must submit the change request within the time permitted for a QME event within your local employer group.

3. **When approved changes take effect.** Changes are effective the first of the month following the receipt of the request or following the event, whichever is later. When the later date is the first of the month, changes are effective that day.

Reminder: If the employee should miss this opportunity to submit a change request, the next chance will be at Open Enrollment or with another consistent Qualifying Mid-Year Event, whichever comes first. If they already have a family membership and need to add eligible dependents, they may add the dependents prospectively.

Personal Changes

Section 4.15: Termination of Employment/Removing Dependents

Termination of Employment
Coverage may continue to the end of the month in which an employee terminates employment as long as the premium is paid in full. Groups do not have the flexibility to extend coverage beyond the end of that month. If premiums have been collected, refunds should be issued rather than extending coverage for an additional month.

If the employee fails to pay the employee portion of the premium, coverage should be terminated on the last day of the month for which the premium has been paid in full. Any claims paid in error after the termination date will be retracted, and the employee will be responsible for reimbursing the cost for any prescription drug claims paid after the termination date.

Faculty members who complete the academic year will have coverage through the end of the contract period (generally, July 31 or August 31) unless coverage is waived, or the employee retires.

Retirees are not eligible to maintain coverage as active employees.

Termination of employment for anyone who is covered under The Local Choice Health Benefits Program at the time of the termination and loses coverage due to the termination event will be offered Extended Coverage.

How to notify TLC of a termination

Terminating an employee & their dependents
TLC Group Adjustment Form: terminates an employee and their dependents (entire contract)

When an employee's coverage is terminated, the coverage for his or her spouse and child(ren), if any, also ends.

Submitting termination information prior to the effective date reduces the chance of paying claims for services rendered after a member's termination date. All requests should be received within 60 days of the termination date.

Removing a family member from an employee's coverage
- To removed covered family members from an employee's coverage, the employee should submit an Enrollment Form.
- Complete all sections, making sure to complete Part 4: Health Care Coverage Election Request.
- All members remaining enrolled in the health plan should be listed in this section.
- The employee needs to sign the form and return it to you for submission to the health plan.

Local Administrative Manual

Section 5 COBRA/HIPAA

COBRA/HIPAA

Section 5.1: COBRA (Extended Coverage)

Extended Coverage (COBRA)
Extended Coverage is a term used by the Department of Human Resource Management (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 a Qualifying Event is a Qualified Beneficiary who may elect to continue coverage under the Local Employer Group's Health Benefits Program for up to 18 months at his or her own expense.

Administration of Extended Coverage
Inspira Financial Health, Inc. serves as the COBRA Administrator for the Commonwealth of Virginia State Employees and The Local Choice Health Benefits Program (TLC).

As part of the administration, they are responsible for the following services:

- Takeover of enrolled qualified beneficiaries
- COBRA election and termination process
- Premium billing and online member payments
- Late Payment Reminder Mailing
- Eligibility updates to carriers
- Plan year updates

They will also be responsible for issuing the following letters/notices:

- Notices sent Proof of Mail
  - General Rights Notice
  - Qualifying Event Notice
- COBRA Termination Notice
- Social Security Disability

Beneficiaries can access their account online at www.inspirafinancial.com. After completing the registration, they may:

- View the benefit plans they are enrolled in.
- Validate their paid to date and payment amount due.
- Make a payment – either one time or set up recurring payments.

COBRA questions should be directed to the Inspira Financial COBRA Department at 888-678-7835 Toll Free Phone (**TTY:711**) Monday through Friday, 7:00 am to 7:00 pm Central Time.

What plans require the offer of Extended Coverage?
Under the TLC program, the health plan is subject to Extended Coverage provisions.

Who is eligible for Extended Coverage?
All TLC groups, regardless of size, must offer Extended Coverage/COBRA to health plan participants who experience a COBRA qualifying event.

When must Extended Coverage be offered?
Two things must happen to generate an offer of Extended Coverage:

1. There must be an Extended Coverage qualifying event; and,
2. The qualifying event must result in a loss of coverage. An event that does not result in a loss of coverage does not require the offer of Extended Coverage.

   For example: While termination of employment is considered an Extended Coverage qualifying event, if the employee did not have TLC Health Plan coverage when the event occurred, no coverage is lost, and no offer is required.

Not all losses of coverage are qualifying events or require the offer of Extended Coverage. For example, coverage lost due to an Open Enrollment election (terminating coverage or reducing membership) should not result in an Extended Coverage offer since Open Enrollment is not a qualifying event.

What is a Qualifying Event?
A qualifying event is a specific event, as described below, that results in the loss of group health plan coverage.

These events include:

- Termination of employment (voluntary or involuntary, except for termination due to gross misconduct*), including Retirement
- Reduction of hours, including Leave Without Pay (not including FMLA—see additional information later in this section)
- Long-term disability
- Moving from full-time to part-time status
- Death of the employee
- Divorce
- Loss of child status

Also, a special rule applies to covered family members of employees who lose coverage due to the employee's termination of employment or reduction of hours when the employee was eligible for Medicare within the 18-month period prior to that qualifying event. In those cases, family members who are Qualified Beneficiaries are eligible for a total of 36 months of continuation coverage starting with the first qualifying event (the employee's Medicare eligibility based on this special rule). This means that they would actually be entitled to 36 months minus any period of continued/concurrent coverage after the employee's Medicare eligibility but prior to the termination or reduction event. As an example, if an active employee is eligible for Medicare effective March 1, 2023, terminates employment and loses coverage on May 31, 2023, covered family members would be entitled to Extended Coverage from June 1, 2023, through February 28, 2026 (33 months from the termination event and 36 months from the employee's Medicare eligibility event). The employee would only be entitled to 18 months of Extended Coverage (and would likely not elect coverage in favor of electing Medicare). Other than this special rule, Medicare eligibility is not a qualifying event for the state program since it does not result in a loss of coverage.

*Gross misconduct is not defined by regulation. Failure to offer Extended Coverage based on gross misconduct should be considered very carefully. Contact the Office of Health Benefits for assistance.

What is NOT a Qualifying Event?
Remember, in order for an Extended Coverage offer to be required, the event must be one of the specific qualifying events listed above, and it must result in a loss of coverage.

This would not include:

- Coverage lost strictly due to an Open Enrollment change (no other simultaneous qualifying event)
- Loss of eligibility for other than a child (unless it was due to another qualifying event such as divorce)
- Coverage lost due to failure to pay a premium
- The start of FMLA
- Termination of employment (or any of the other listed events) when there is no coverage lost (e.g., employee had waived coverage)
- Reduction of hours to a leave with pay when there is no resulting loss of coverage.

What is a loss of coverage?

For purposes of Extended Coverage, loss of coverage means a change in the terms and conditions of coverage. This often means simply that the coverage is terminated, but it could also mean that the employer premium contribution for coverage is lost (e.g., on certain leaves without pay or long-term disability) or any other change in the way that coverage is provided.

Who is Covered?

An employee, spouse or child who is covered on the day before the qualifying event and loses coverage due to that event should be offered the opportunity to elect Extended Coverage. These terminated health plan participants are called Qualified Beneficiaries. Other Qualified Beneficiaries include:

- A child who is born to or placed for adoption with the covered employee during the Extended Coverage period.
- A participant whose coverage is terminated in anticipation of a qualifying event (for example, a spouse who is terminated at open enrollment prior to a pending divorce). *

*Example: Employee covers his/her legal spouse. At open enrollment, the spouse is dropped from membership. Three months later, their divorce is finalized. The employee is allowed to drop the spouse at open enrollment, but under these circumstances, the spouse does not lose Extended Coverage rights. If the spouse provides a Qualifying Event Notice (see Notices) within 60 days of the date coverage would have been lost due to the qualifying event (the end of the month in which the final divorce occurs), an Election Notice should be generated, and the spouse will be eligible for Extended Coverage for up to 36 months after the loss of coverage due to the qualifying event (divorce), but not for the period between the loss due to Open Enrollment and what would have been the loss due to the divorce. Sometimes the determination of "in anticipation of the qualifying event" is very clear, and sometimes it is not. Contact the Office of Health Benefits if assistance is needed in making this determination.

What are the rights of Qualified Beneficiaries?

- Each Qualified Beneficiary has the right to elect Extended Coverage independently. This means that a family group who is offered Extended Coverage may choose to enroll any or all Qualified Beneficiaries. However, multiple family members may continue to be covered under dual or family memberships.
- Qualified Beneficiaries have the same rights as similarly- situated non-extended Coverage participants. This means that they can make plan and membership changes like any program participant.
- Qualified Beneficiaries may elect coverage that is identical to that which they had prior to the qualifying event. No plan change is allowed at the start of Extended Coverage.
- Qualified Beneficiaries have a 60-day election period starting with the later of the date that coverage is lost due to the qualifying event or the date that the election Notice is provided.

Can anyone other than Qualified Beneficiaries be covered through Extended Coverage?
Since Qualified Beneficiaries have the same rights as non-Extended Coverage plan participants, they can add eligible family members at open enrollment or with a qualifying mid-year event. However, other than those who meet the eligibility criteria to be Qualified Beneficiaries as described above, any other participants added to an Extended Coverage membership will not be Qualified Beneficiaries. This means that they do not have independent rights to coverage, and their continued participation is dependent on the enrollment of the Qualified Beneficiary through whom they gained eligibility. For example, an Extended Coverage/COBRA participant who lost coverage due to reaching the limiting age may add his/her own newborn to coverage, but since the newborn is not the child of the covered employee (but rather of the covered family member), the newborn would not be a Qualified Beneficiary and would lose coverage if the original Qualified Beneficiary terminated coverage (e.g., failed to pay the monthly premium within the payment grace period).

HIPAA Financial Responsibility
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, 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, 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 Group Benefits Administrator 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, which outlines responsibilities for compliance with HIPAA regulations.

The following HIPAA forms can be found at www.thelocalchoice.virginia.gov.
- Memorandum of Understanding
- Employee/Retiree Privacy Notice (HIPAA Privacy Notice)
- Authorization to Use and Disclose Protected Health Information (HIPAA Authorization Form)
- Certificate of Group Health Plan Coverage (Certificate of Creditable Coverage)

The Local Employer must use TLC HIPAA forms or assume financial responsibility for errors. Copies of TLC HIPAA forms are found at www.thelocalchoice.virginia.gov.

Local Administrative Manual

Section 6 Using the Coverage

Using the Coverage

Section 6.1: ID Cards

An identification card is the key to receiving services covered under the health plan. Members should carry their identification cards at all times and present them to health care professionals whenever they are seeking treatment.

Members in the statewide active health plan have one card for medical/vision/behavioral health/prescription drug and dental.

ID cards contain information that is valuable both to your employees and providers, like the member's ID number, group number, benefit information and Member Services phone numbers.

Use of an ID card by anyone other than the member named on the card (or covered family members) for the purpose of receiving services constitutes fraud. Penalties for fraud include immediate termination of coverage and criminal prosecution.

Note: If the group's benefits are not changing, new ID cards may not be issued at renewal.

How to request ID cards

Anthem automatically issues ID cards for:

- a new enrollment;
- when a plan is changed; or
- when a name is changed.

Members in a statewide plan can contact the ID Card Order Line at 1-866-857-6713 or Anthem BCBS Health Guides at 1-800-552-2682 to request replacement ID cards. A PDF card can be issued on the same day requested. Delivery of the actual ID card takes 7 – 10 business days.

Members in a statewide plan also have access to view their ID cards through the Sydney Mobile Health App and by logging into www.anthem.com/tlc.

When an address needs to be changed, the Local Employer Group should submit the TLC Personal Data Change Form (www.thelocalchoice.gov) and wait 2 – 3 business days to request a replacement ID card from Anthem.

For those members enrolled in the Kaiser HMO, contact Kaiser at 800-777-7902 to request replacement cards.

For those members enrolled in Sentara Health Vantage HMO, contact Sentara Health at 866-846-2682 to request replacement cards.

Using the Coverage

Section 6.2: Claims Procedures

Under most circumstances, employees and retirees in the The Local Choice Health Benefits Program (TLC) do not have to file claims for health care services. For Example, with the Key Advantage plans, all in-network providers, and many non-network providers, submit claims directly.

When an enroll receives health care services

- The identification card should be presented.
- The enroll should request that he provider submit the claim directly to the appropriate health benefits plan administrator.

Because in-network providers and many out-of-network providers routinely file claims and are familiar with claims procedures, having them file the claim will expedite payment for approved covered services.

A member may need to pay for services and manually file a claim if they:

- do not present their member ID card when services are received;.
- receive treatment from an out-of-network doctor, hospital or other health care professional; or
- fill prescriptions with an out-of-network pharmacy.

For claims filed by members, plan administrators typically send reimbursement checks and Explanations of Benefits (EOBs) to the member. It is his/her responsibility to pay the health care professional.

Additionally, the out-of-network health care provider may balance-bill the member. Balance-billing can occur when the fee charged by the out-of-network provider is more than what the plan administrator has agreed to pay in-network doctors for the same services, and there is a balance remaining after receiving reimbursement from the plan administrator.

Prescription drug claims

When a member of your group presents their ID card at an in-network pharmacy and pays the appropriate copayment at the time the prescription is filled, the pharmacy will file a claim directly on the member's behalf. If a member does not show their ID card, or if the pharmacy is not in-network, the member may need to pay for the prescription in full and then file a Prescription Drug Reimbursement Form. Due to balance billing, the amount reimbursed may be less than the amount the member paid.

Vision claims

Anthem's Blue View Vision program offers members a hassle-free experience when visiting their vision care provider. For in-network services, members are only responsible for the designated plan copays and any other incurred charges. Providers verify eligibility and submit claims for reimbursement. For out-of-network services, benefits will be covered at a lower payment level. Members will need to pay for covered services and purchases at the time of their visit and send an out-of-network claim form to Blue View Vision.

Dental claims
In most cases, an in-network dental professional will file a claim on the member's behalf. If the dental professional cannot file a claim, the member must submit a completed claim form and attach itemized bills for covered services.

The dentist can assist the member with the information needed on the claim form (dental codes, for example). Claims for dental services should be sent to the dental plan address shown on the member's ID card.

Claim Forms are located on each plan administrators dedicated website.

- Anthem Blue Cross & Blue Shield (medical, behavioral health, outpatient prescription drugs and routine vision: www.anthem.com/tlc
- Delta Dental: deltadentalva.com
- Kaiser Permanente: http://my.kp.org/commonwealthofvirginia
- Sentara Health: www.sentarahealth.com/cova

Claims Filing Steps
There are, however, times when the health care provider does not bill the health benefits plan directly. In these instances, the enrollee must file a claim.

Claims procedures will vary from plan to plan, but generally the enrollee must follow these steps if the health care provider does not file the claim.

1. Complete a claim form provided by the health benefits plan. Carefully follow instructions on the form.

2. Attach a copy of a fully itemized bill to the claim form. An itemized bill usually includes:
   - Patient's name
   - Provider's name
   - Date of each service
   - Description and cost of each service
   - Diagnosis of the condition

3. Forward the claim form and itemized bill to the address shown on the form.

If there are questions about completing the form, attachments to the form, or the claim's status, the enrollee should contact the appropriate health benefits plan administrator.

Timely filing is important. Employees should consult their plan's member handbook for specific claims filing deadlines. Claims forms are available through the plans.

Using the Coverage

Section 6.3: Coordination of Benefits

Coordination of Benefits
Coordination of Benefits (COB) applies to members of your group who are covered by more than one health care plan. Coordination of benefits helps ensure that members covered by more than one plan will receive the benefits they are entitled to while avoiding overpayment by either plan. Coordinating benefits is one of the ways The Local Choice Health Benefits Program (TLC) works to keep premiums at a minimum.

Coordination of Benefits (COB) is a method which avoids duplicate payments for the same service. All TLC health benefits plans provide for coordination of benefits. If a person covered by the TLC plan has additional health care coverage, benefits will be coordinated with the other plan if that plan involves employer contributions or payroll deductions and if the other plan is:

1. a group plan;
2. a labor-management trusted plan, union welfare plan, employer organization plan, or employee benefit organization plan; or
3. a governmental program or coverage required or provided by law.

COB does not apply when someone has an individual accident or sickness policy paid for by the insured or when an employee funds an individual or franchise sickness or accident insurance policy through payroll deduction. For instance, if an employee has a cancer policy paid 100% by the employee for which payroll deductions are taken, there is no COB.

With COB, one of the programs is responsible for "primary coverage" and the other for "secondary coverage." Full benefits are paid by the primary coverage program before benefits of the other programs are calculated. Secondary coverage programs provide benefits only for covered services which are not payable by the primary coverage. When the TLC plan pays secondary, the payment will be calculated such that the combined primary and secondary coverage will not exceed what the TLC would have paid if it were the primary payor.

The decision of which coverage will be primary or secondary is made using the order of benefit determination rules. Highlights of these rules are described below:

- If the other coverage does not have COB rules substantially similar to Your Health Plan's, the other coverage will be primary.
- If a Covered Person is enrolled as the employee under one coverage and as a dependent under another, generally the one that covers him or her as the employee will be primary.
- If a Covered Person is the active employee under both coverages, generally the one that covers him or her for the longer period of time will be primary.
- If the dependent is covered as a dependent on their parent(s) plan and they are also covered as a dependent on their spouse's plan, the spouse's plan is primary.
- If the Covered Person is enrolled as a dependent child under both coverages (for example, when both parents cover their child), typically the coverage of the parent whose birthday falls earliest in the calendar year will be primary.

- Special rules apply when a Covered Person is enrolled as a dependent child under two coverages and the child's parents are living apart. Generally, the coverage of the parent or stepparent with custody will be primary. However, if there is a court order that requires one parent to provide health care for the child, that parent's coverage will be primary. If there is a court order that states that the parents share joint custody without designating that one of the parents is responsible for medical expenses, the coverage of the parent whose birthday falls earliest in the calendar year will be primary.
- If a covered active employee or employee's dependent also has other coverage as a retiree or laid off employee, the active coverage is primary and the other coverage is secondary.
- If a covered active employee or employee's dependent is also covered by Medicare, the coverage provided by the employer is primary (unless Medicare eligibility is due to End Stage Renal Disease and the coordination period has been exhausted).
- If a covered retiree, survivor or their covered dependent is eligible for Medicare, the Medicare-eligible member is no longer eligible for coverage under Your Health Plan (except during an End Stage Renal Disease coordination period). Refer to the **Eligibility, Enrollment and Changes** section of the member handbook under **When You Become Eligible for Medicare** for more information.

When the Health Plan is the primary coverage, it pays first. When the Health Plan is the secondary coverage, it pays second as follows:

- The Plan Administrator calculates the amount the health plan would have paid if it had been the primary coverage, then coordinates this amount with the primary plan's payment. The TLC health plan's payment in combination with the other plan's payment will never exceed the amount the TLC health plan would have paid if it had been your primary coverage.
- Some plans provide services rather than making a payment (i.e., a group model HMO). When such a plan is the primary coverage, the TLC health plan will assign a reasonable cash value for the services and that will be considered the primary plan's payment. The TLC health plan will then coordinate with the primary plan based on that value.
- In no event will the TLC health plan pay more in benefits as secondary coverage than it would have paid as primary coverage.

Other COB issues

Often, some or all of the costs of medical care are the responsibility of an insurance party other than TLC:

- Members who are injured or become ill as a result of work related accidents or environment are eligible for benefits under the Workers' Compensation Law. If Workers' Compensation denies all or part of a claim, TLC will review the claim to determine whether to pay benefits as the secondary carrier.
- TLC will not pay for benefits if coverage would be available to the member under government programs, with the exception of Medicaid.
- In certain situations, Medicare may be a participant's primary or secondary coverage. We will coordinate benefits with Medicare according to the Medicare Secondary Payer rules.

Local Administrative Manual

Section 7 Special Circumstances

7.1 Family Members Without a Social Security Number

Special Circumstances

Section 7.1: Family Members Without a Social Security Number

Family Members Without a Social Security Number

Employees are generally required to provide Social Security numbers (SSNs) for their eligible family members when they enroll. There are two specific situations when an SSN is not available for an eligible dependent.

1. **Enrolling Newborns**
   Newborns may be temporarily added to the Cardinal system. Once the permanent social security number has been obtained for a newborn, the employee must submit the information to the Benefits Administrator.

2. **Dependents who are Foreign Nationals/Aliens:**
   Alien/non-citizen dependents may not be able to provide an SSN but may instead present an Individual Taxpayer Identification Number (ITIN). This is acceptable since legally admitted aliens who do not have authorization to work in the United States do not have SSNs.

   The Social Security Administration can provide a letter of denial to those not eligible for an SSN. The employee must provide a copy of this letter along with a copy of the documents allowing entry into the country (Visa) with their enrollment request.

   Once the documentation of the ITIN or the paperwork validating the dependent's status in the country is received, they may be added to the Cardinal system. Please ensure that the ITIN is provided on the TLC enrollment form.

Local Administrative Manual

Section 8 Cardinal HCM

Cardinal HCM

Section 8.1: Cardinal HCM

Cardinal HCM is the official source of eligibility and enrollment data for The Local Choice Health Benefits Program (TLC). It collects, validates, and distributes enrollment and billing data to plan administrators. Reports can be extracted in the Cardinal HCM system. It is managed by the Department of Human Resource Management (DHRM).

Information entered into Cardinal HCM is processed daily and files are created for health plan vendors. The vendors use these files to update their systems with additions, changes, and terminations. Health care vendors and payroll offices may access updated files daily.

You should contact DHRM with questions about eligibility and enrollment. The Enrollment Forms and other group adjustments should also be sent to DHRM.

Cardinal HCM

Section 8.2: Cardinal HCM Reports

What is Cardinal HCM?
Cardinal Human Capital Management (HCM) is the benefit eligibility system for localities participating in The Local Choice Health Benefits Program (TLC).

The Cardinal Catalog lists available key reports and queries, with a description of each. Here are some recommended reports:

- Health Plan Participants Report (RBN054): lists all employees enrolled in healthcare on a specific date. It includes the Benefit Plan, Coverage Level, and Coverage Begin Date.
- Benefit Enrollment Changes Report (RBN287) *: lists benefit changes that were made between two date parameters.
  - Navigation: Cardinal Homepage > Navigator > Benefits > Reports > Benefit Enrollment Changes
- Benefit Event Status Report (RBN300): lists all participants in a particular process status or set of status levels.
- ACA Reconciliation Report (RBN218): lists individual health benefit information for localities to validate prior to Affordable Care Act (ACA) reporting, containing a line for each participant and dependent with coverage in the calendar year.
- Benefit Eligibility Audits Report (RBN301): lists employees and associated dependents approaching an age-related milestone. The report also identifies outstanding approvals for new dependents and disabled dependents that may need to be re-certified as disabled.
- Cardinal Enrollment Report (RBN350) *
- Health Census Query (V_BN_HEALTH_CENSUS) *

A brief description of the reports as well as the navigation paths, can be found beginning on the next page

Benefits Enrollment Changes Report

Benefit Enrollment Changes Report (RBN287)

REVISED: 09/15/2021

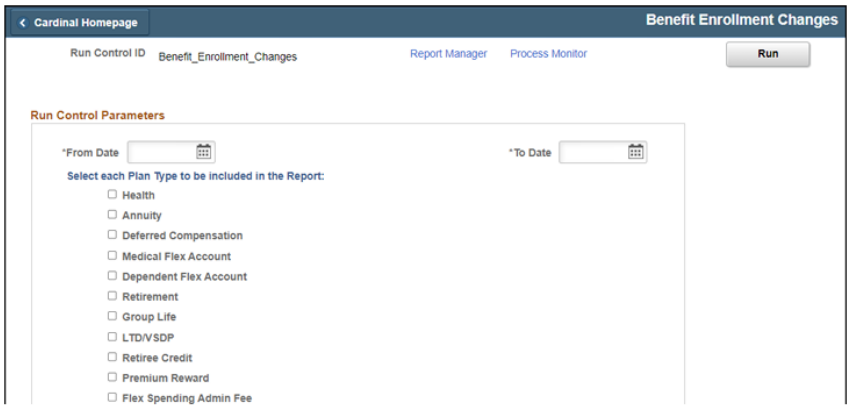
DESCRIPTION:
This report lists all employees who enrolled in benefits or made changes to existing benefits within a specific date range.

NAVIGATION PATH:
Navigator > Benefits > Reports > Benefit Enrollment Changes

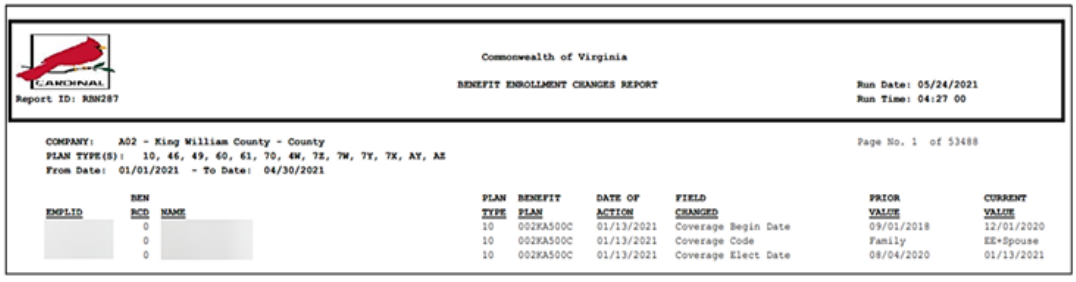
INPUT / SEARCH CRITERIA:
From Date
To Date
Plan Type (s)
Company (s)

OUTPUT FORMAT:
PDF

Screenshot of the Benefit Enrollment Changes Report Run Control Page

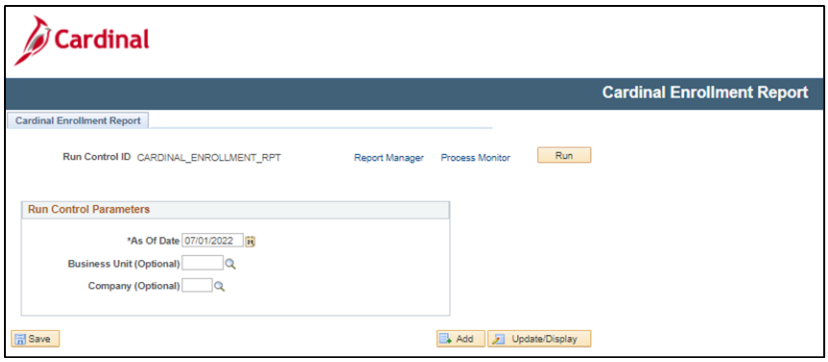


Screenshot of the Benefit Enrollment Changes Report



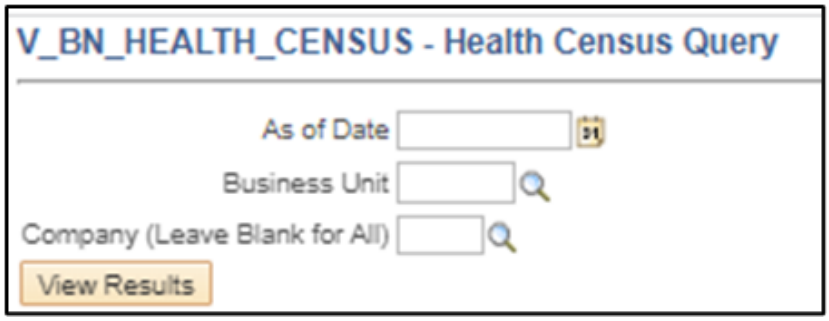
Cardinal Enrollment Report

- Description: This Excel report provides employee benefit enrollment information.
- Output Format: Excel Spreadsheet
- Navigation Path: Benefits > Reports > Cardinal Enrollment Report
- Report Name: Cardinal Enrollment Report



Health Census Query

- Description: This query will provide a listing of employees and dependents that are enrolled in healthcare as of a certain date.
- Output Format: Excel Spreadsheet
- Navigation Path: Reporting Tools > Query > Query Viewer
- Query Name: V_BN_HEALTH_CENSUS



Additional details on these reports can be found in the HCM Reports Catalog. For any questions regarding these new reporting options, please submit a help desk ticket to vccc@vita.virginia.gov and include "Cardinal BN – Reporting" in the subject line. Please include your name, email address, and a phone number where you can be reached.

Local Administrative Manual

Section 9 TLC Premium and Accounting Procedures

TLC Premium & Accounting Procedures

Section 9.1: Cardinal HCM & Anthem Group/Billing Numbers

Cardinal HCM Group Number	Anthem Billing Number
• **Example: ABC Group: 047 123 00** 047 = Government Group 123 = Group Number 00 = Group Subdivisions (county library, water authority, etc.). • Should be used on all DHRM forms (Enrollment Forms, Group Adjustment Forms, Employer data Sheet, Personal Data Change Form). • All active, early retirees, COBRA and Medicare eligible, etc. will have the same group number. • Group Subdivisions - Some local employers have multiple employers – each with a separate federal employer identification number (FEIN). For example, a single group may have participants from the County, PSA, DSS and the Library. Each of the four employers has a separate FEIN. In order to file accurate ACA Employer reports, TLC needs to have the County group subdivided by each employer's FEIN in Cardinal. TLC must create a group subdivision for County participants, one for PSA participants, one for DSS participants, and one for Library participants with the appropriate FEIN attached. The last two digits of your Cardinal Group Number will identify the group subdivision.	• **Example: ABC Group: T71230MA24** T7 = Government Group (T8 = School Group) 123 = Group Number 0 = Location M = Medical A = Billing Option (A = Active) 24 = Plan Code (24 = Key Advantage Expanded with Comprehensive Dental) • The Anthem bill will break out actives versus early retirees, Medicare, etc. using the billing number. • Anthem billing number is not cross-referenced in the Cardinal HCM eligibility system. This number should not be provided on any TLC forms (including enrollment forms and the Group Data Change Form).

TLC Premium & Accounting Procedures

Section 9.2: Billing

Billing
Your Group Bill does more than just tell you how much your group owes. It gives you a chance to make sure that our records accurately reflect any changes you've requested. The Group Bill also gives you all the information you need to help you make the payments for your group's coverage on time.

The Local Choice Health Benefits Program (TLC) 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 TLC informed of the membership status of employees. Remember to notify TLC at the Department of Human Resource Management (DHRM) of any changes in your group as soon as they occur.

DHRM transfers enrollment data from Cardinal HCM to the billing administrators. Anthem handles both direct billing and group billing for all TLC statewide plans. The regional plans handle their own HMO billing.

You will receive a separate group bill for each group subdivision.

Reconciling invoice (billing) discrepancies
Discrepancies should first be checked in Cardinal HCM. You can check the Benefit Enrollment Changes Report (RBN287) to see if and when your change was entered in Cardinal HCM. Changes not in Cardinal HCM should be reported to TLC at DHRM. Changes in Cardinal HCM but not on the invoice should be reported to Anthem or the appropriate regional plan. The timing of your change request will affect the invoice.

Benefit Enrollment Changes Report: See the Cardinal HCM Reports section for more detail on how to find the Benefit Enrollment Changes Report in Cardinal HCM.

When payment is due
The regulations that govern the program require that TLC groups remit their monthly premiums 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, 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 Group 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 enrollees of the delinquency and restriction on claims payment.

TLC Tip: TLC Billing Dates
- 1st of month: premiums due
- 10th of month: invoice created for the next month's premiums

TLC Premium & Accounting Procedures

Section 9.3: Direct Bill Members

If your group has elected direct bill for early retirees or Medicare eligible participants, these members will receive their premium billing statements directly from Anthem BCBS. Members will receive their billing statement around the 10th of the month for the next month's premium. Members will have a grace period of 45 days before medical coverage is cancelled for non-payment. However, if a member is not paid to date, their prescription drug coverage will be suspended (regardless if the member is still in their grace period).

Direct billed members have the option to sign up for automatic bank draft. Premiums will be drafted from the member's checking account on the 1st of each month. Please have your employee contact the plan administrator at the number on the back of their ID card for further assistance.

As members become eligible for a direct bill subgroup, please notify them of the direct bill process. Member notification is the responsibility of the Group Benefits Administrator.

How to identify participants who are direct billed
These members are included in the Cardinal Enrollment Report (see section on Cardinal HCM Reports).

Anthem BCBS will notify the Department of Human Resource Management (DHRM) when a direct bill participant fails to pay and the coverage will be terminated in Cardinal.

TLC Premium & Accounting Procedures

Section 9.4: School Groups with 10 Month Rates

School Groups with 10 Month Rates

Eligibility for The Local Choice Health Benefits Program (TLC) Coverage
Health plan coverage is available to full-time or part-time employees who meet your eligibility guidelines. For the purpose of health plan eligibility, a full-time faculty member must work 30 or more hours per week. This will include limited appointments if the employer knows at the start of employment that the employee will work 30 or more hours per week, even if the employee is hired for a limited time (e.g., one semester). Regardless of the length of the faculty member's contract, there is no waiting period for health plan coverage.

Health plan coverage for eligible faculty members will be effective the first of the month coinciding with or following the first day of employment if the enrollment is completed within the 30-day window. Eligibility for coverage may continue until the end of the month in which the employment period ends as defined by contract, the health plan coverage ends as defined by policy, or employment is otherwise terminated.

Coverage During Summer Months
The start of coverage for faculty members often coincides with the academic year (starting August or September 1), runs for 12 months, and can include summer months when the faculty member may not be actively at work. However, if a faculty member terminates employment during the academic year, coverage will terminate at the end of the month in which the termination event occurs. Faculty members who retire at the end of the academic year and are eligible for and elect to enroll in TLC (if offered) may not maintain active employee coverage during any summer months after their retirement date, regardless of the provisions of his or her employment contract.

If eligibility for coverage during the summer months is otherwise available based on contract or policy, it is not contingent upon a contract for the next academic year.

Collecting Premiums During the Summer Months
Premiums for the summer months must be collected by payroll deduction or by personal check if an employee with premium liability does not receive pay during the summer months. Premiums paid by personal check are due the first day of the coverage month. If timely premium is not received, notify the employee in writing that there is a grace period of 30 days from the first of the month for which the premium was due.

If the faculty member fails to make payment for his/her share of the premium during the summer months, coverage must be terminated on the last day of the month for which premium payment in full has been received, and the Cardinal record must be terminated accordingly.

Terminating School Employees with 10 Month Rates
For terminating school employees with 10-month rates, coverage continues through the summer and no refunds will be issued.

TLC Premium & Accounting Procedures

Section 9.5: Group Termination

For information on termination, please reference 1 VAC 55-20-160, 1 VAC 55-20-290 and 1 VAC 55-20-300 of the Virginia Administrative Code. According to these regulations, if you choose to terminate participation in The Local Choice Health Benefits program (TLC), the Department of Human Resource Management (DHRM) must receive written notification at least 90 days prior to the date of termination.

DHRM will notify a terminating local employer of any Adverse Experience Adjustment (AEA) 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. See the Withdrawal & Adverse Experience Adjustment (AEA) Determination section of this manual for more information on the AEA.

Local Administrative Manual

Section 10 Underwriting Policies

Premium Development

Regional HMO Rating Pools
Premiums for the Regional HMO plans are community rated. The size and demographic composition of an individual employer are not applicable.

Self-Funded Rating Pools
In addition to your group's specific demographics, the following medical rating pools (based on group size) are used to develop rates for the statewide self-funded plans. Each employer group's premiums are developed based on the relationship of group-specific information to the pool norm for the appropriate rating geographical areas.

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

Community/Pooled Rating - Group size of 1 through 99 employees.

Experience Rating - Group size of 100 or more employees. The Credibility Factor applies to medical and behavioral health components only. All outpatient prescription drugs and routine dental claims are pooled, based on the combined experience of all current TLC groups, regardless of size.

Group Size	Credibility Factor for Medical & Behavioral Health Experience		
	Current Year	Prior Year	Pool
1-99	0%	0%	100%
100 - 249	27%	18%	55%
250 - 499	43%	28%	29%
500+	60%	40%	0%

Excess Claims Limits (Specific Stop-Loss)
The program self-funds excess claims. The impact of this benefit is to spread the cost of catastrophic claims over the entire TLC program, sharing the risk among all of the member groups. The excess claims limits will vary based on employer size. To protect participating employers, TLC provides shared risk/stop loss protection through medical attachment points (Specific Pooling Points) of $125,000 for groups with fewer than 300 participating employees; $150,000 for groups between 300 and 999 participating employees; $200,000 for groups between 1,000 and 1,499 and $250,000 for groups with 1,500 or more employees.

Monthly rates for employee plus one and family are calculated as a factor of the single employee rate. The relationship between the single, dual, and family rates remains the same as in the current plan year: Single = 1, employee plus one = 1.85 X single rate, and family = 2.70 X single rate.

Outpatient Prescription Drug and Routine Dental Premiums

In all statewide self-funded plans premiums for the Outpatient Prescription Drug and Routine 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 statewide self-funded plans.

Underwriting Policies

Section 10.2: Employer Contributions

Employer Contributions
To provide more flexibility, employers offering multiple plans may choose to determine one minimum premium contribution requirement for all plans except for the TLC HDHP, which must be determined separately (see below). Premium averaging (if selected) will be based on the average single premium for all included plans.

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 Code of Virginia-required Key Advantage 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 (if coverage is offered)

- Minimum of 50% of the amount contributed toward Full Time employee coverage at all membership levels*

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

If the local employe elects to offer retiree coverage, contributions toward the cost is permitted but not required.

Minimum employer funding for the HDHP is always determined separately from the Key Advantage and Regional plan requirements. If the HDHP is offered, an employer must pay a minimum of 80% of single premium and 20% of the additional dependent premium. If 75% of all eligible employees enroll and the employer funds an HSA/HRA, the 20% dependent contribution requirement is waived. For part-time participants, the 50% rule above will apply. Groups may make a higher contribution if they wish.

Underwriting Policies

Section 10.3: Group Withdrawal & Adverse Experience Adjustment (AEA) Determination

GROUP WITHDRAWAL – NOTICE TIMING AND ADVERSE EXPERIENCE ADJUSTMENT

To protect current groups in The Local Choice Health Benefits Program (TLC), 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.

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).

Sections 1VAC55-20-160 D and 1VAC55-20-300 of the Virginia Administrative Code, the regulations under which TLC operates, provide for a potential AEA to withdrawing employers. This adjustment requires any withdrawing employer to contribute their pro rata share of any operating loss experienced during prior plan years. Although the regulations permit a multi-year review of profits and losses, it is the policy of the Department of Human Resource Management (DHRM) to confine any applicable AEA to the experience of the last plan year during which the employer was a member.

DHRM will notify a terminating local employer of any AEA within six-calendar months of the time the local employer group terminates participation in the program. Further DHRM 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 group in 12 equal monthly installments beginning 30 days after the date of notification by DHRM. In the event that a terminating local employer group requests, in writing, an extension beyond a period of 12 months, DHRM may approve an extension up to 36 months provided the local employer agrees to pay interest at the statutory rate on any extended payments. Since AEA is an exact look back limit of liability, it cannot be estimated.

The following illustrations have been prepared to assist our members in understanding how an Adverse Experience Adjustment (AEA) would be calculated.

The basis for determining any AEA will be (1) the amount of the program's loss for the most recent plan year, (2) the experience of the employer, and (3) the proportion of the employer's enrollment to the enrollment for the entire category. Employers are divided into three categories.

1. Employers with 1 to 99 enrollees (Pooled)
2. Employers with 100 to 499 enrollees (Blended)
3. Employers with 500+ enrollees (Experience Rated)

A statement of income and expenses is prepared for each category based upon its experience. (The third category is comprised of experience rated employers. Each group is responsible for their own claims, whether or not the entire category of experience rated employers sustains a loss.)

EMPLOYERS WITH FEWER THAN 500 ENROLLEES (CATEGORIES 1 & 2)
The first step in the adjustment process is to determine the total number of contract units (C/Us) for each category for the past plan year. A contract unit is determined by the following factors applied to the type of membership times the number of month's participation for each enrollee: an employee only contract has one C/U; an employee plus one contract has 1.85 C/Us; a family contract has 2.7 C/Us. Therefore, the number of contracts by each membership type is accumulated, and the total contract units for that category is computed based on the stated factors as follows:

Type of Membership	Total Contracts	C/U Factor	Total C/Us
Employee only x 12 =	4,500	1.0	4,500
Employee + One x 12 =	2,200	1.85	4,070
Family x 12 =	3,300	2.7	8,910
Total	**10,000**		**17,480**

The next step is to determine the total number of contract units for the withdrawing employer during the plan year using the same method illustrated above. The withdrawing employer's pro rata share of the contract units is then applied to the category's loss to determine the adverse experience adjustment for the withdrawing employer. The following example illustrates an adverse experience calculation for employers in categories 1 and 2.

EXAMPLE *:
ASSUMPTIONS: Loss for the category is $1,000,000. Total category contract units equal 17,480. The terminating employer had 1,878 C/Us during the review year.

1. Employer's C/Us divided by category's C/Us equals employer's pro rata share.
2. Employer's share times the category's loss equals the employer's Adverse Experience Adjustment.

CALCULATIONS: 1,878 / 17,480 = 10.74% X $1,000,000 = $107,437

In the example, the employer would have an Adverse Experience Adjustment of $107,437 at the time of termination. The terminating employer would be notified of this amount within 6 months of termination, and the employer would be required to pay the adjustment in up to 12 equal installments beginning 30 days after the notification by the Department.

It is possible that one category could experience a loss, subjecting employers in that category to an Adverse Experience Adjustment, while another category could operate at a surplus and require no Adverse Experience Adjustment to a terminating group.

* Examples are for illustration only and have no bearing on the actual experience of a pool/category or individual group.

EMPLOYERS WITH OVER 500 ENROLLEES (CATEGORY 3)
The maximum Adverse Experience Adjustment which would be due from each terminating employer in this category would be that employer's loss during the immediate past plan year based upon the employer's plan(s) expenses and its pro rata share of the program overhead. Prior years' performance during which the employer was experience rated would be taken into consideration, if favorable to the employer, but the AEA would never exceed the last plan year's loss.

An employer in this category withdrawing at the end of a year in which they did not have a loss would not be assessed an AEA.

Another employer that withdrew with a $100,000 loss during the last plan year would be subject to a maximum AEA of the $100,000 loss paid in equal installments over a 12-month period. An illustration follows:

SAMPLE ILLUSTRATION * ANY CATEGORY 3 EMPLOYER
THE LOCAL CHOICE HEALTH CARE PROGRAM
Operating Statement
July 1, 2022 through June 30, 2023

INCOME	$1,519,543
EXPENSES:	
• Incurred Claims	$1,417,129
• Contractor Administration	128,107
• Pooled Capitation (Rx, Dental and MISA)	55,290
• Program Overhead	19,017
Total Expenses	$1,619,543
GAIN OR (LOSS)	($100,000)

If this employer had withdrawn on June 30, 2023, the maximum Adverse Experience Adjustment (AEA) would have been the operating loss of $100,000. However, prior year's accumulated gains could be applied to reduce any current year loss.

Likewise, if an employer withdraws from the program and the review analysis reflects a gain for the immediate past plan year, there would be no AEA, even if their accumulated experience was a loss.

* Examples are for illustration only and have no bearing on the actual experience of a pool/category or individual group.

Underwriting Policies

Section 10.4: Retiree Coverage Funding Options

A local group employer may add retiree coverage at renewal by submitting a written request to the Department of Human Resource Management (DHRM) along with an approved resolution from your Board or Governing Body.

Although allowed, the employer is not required to contribute to the cost of the early retiree or Medicare eligible retiree coverage.

Early Retiree Funding
Employers may choose to offer retiree coverage for those retirees who are not eligible for Medicare.

All groups (with exception of groups that have been grandfathered) will receive rates for blended premiums. In a blended premium, active employees and non-Medicare-eligible retirees will have the same rates.

While blended rates 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.

Stand-alone rates for non-Medicare-eligible retirees are grandfathered, which means that they are only available for groups who currently offer them.

Medicare Eligible Retiree Funding
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.

Note: Retiree coverage is available but not automatically provided. If Retiree coverage is chosen, the employer may elect to cover retirees not eligible for Medicare (early retirees) only, or both early retirees and Medicare eligible retirees. 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.

Local Administrative Manual

Section 11 Disputes & Appeals

Disputes & Appeals

Section 11.1: Appeals

The appeals process provides employees with the full and fair opportunity to request reconsideration of coverage decisions with which they disagree.

Members have access to both a complaint process and an appeal process. Should they have a problem or question about the Health Plan, the appropriate Plan Administrator's Member Services Department will assist them. Most problems and questions can be handled in this manner.

Complaints typically involve issues such as dissatisfaction about the Health Plan's services, quality of care, the choice of and accessibility to the Health Plan's Providers and network adequacy.

Appeals typically involve a request to reverse a previous adverse decision made by the Health Plan. You may also request to reopen a claim without invoking the appeal process when there are claim errors or claims are denied for insufficient information.

Appeals Process: Steps for the appeals process can be found in the appropriate plan administrator's TLC member handbook.

The Appeal Form can be found at: https://www.thelocalchoice.virginia.gov/forms.html

Disputes & Appeals

Section 11.2: Ombudsman

The Department of Human Resource Management (DHRM) 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:

1. Assist covered employees in understanding their rights and the processes available to them according to their state or local health plan.
2. Answer inquiries from covered employees by telephone and electronic mail.
3. Provide information to covered employees concerning the TLC health plans.
4. 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 site utilized by the DHRM.
5. Maintain data on inquiries received, the types of assistance requested, any actions taken and the disposition of each such matter.
6. 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.
7. 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.
8. 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.

Local Administrative Manual

Section 12 Additional Administrative Information

Additional Administrative Information

Section 12.1: New Enrollment Effective Dates

New Enrollment Effective Dates
Ensuring a successful initial enrollment for a newly eligible employee is the first important step in administering health benefits.

It is the Group Benefits Administrator's responsibility to see that each newly eligible employee receives complete and timely health information. This generally means distributing printed materials, but could also mean conducting benefit orientation sessions, meeting with newly eligible employees as soon as possible so they can meet enrollment deadlines and helping an employee use Cardinal Employee Self- Service for the first time. The timeliness of completing the enrollment process is also critical. The enrollment deadlines described below apply health benefits.

Newly Eligible Employee Enrollment Procedures

1. Newly eligible employees (new hires) have up to 30 calendar days to enroll in a health plan. The 30-day countdown period begins on the first day of employment and ends 30 days later. If the enrollment action is received within the 30 calendar day time frame, coverage will be effective the first of the month coinciding with or following the date of employment.

2. A probationary or waiting period before the effective date may be applied if uniform for all employees. Waiting periods may not exceed 59 days.

   Example: Locality has a 0-day waiting period for the new hire
   - Employee is hired on February 10 and agency receives the enrollment action on February 18. Coverage is effective March 1.
   - Employee is hired on February 10 and agency receives the enrollment action on March 5. Coverage is effective on March 1.
   - If employment begins on February 1 and the enrollment action is received within 30 days of the employment date, the coverage is effective February 1.

   There is no discretion allowed in this area. Coverage will always be effective as described above. In no case will coverage begin before the eligible employee's first day of employment. It is up to the employer to provide the hire date/first day of employment, including a holiday or weekend.

   Example: Locality has a 2-day waiting period for the new hire
   - Employee is hired on February 10. He has to wait 2 days to gain eligibility agency receives the enrollment action on February 18. Coverage is effective March 1.
   - Employee is hired on March 30. He has to wait 2 days to gain eligibility for health insurance. agency receives the enrollment action on April 3. Coverage is effective on May 1.

3. If the employee does not enroll during the initial 30-day period: If the employee does not enroll within the first 30 days of becoming eligible based on the locality new hire rule, he or she will not have coverage and may enroll only.
   - During the annual open enrollment period, or
   - If the employee experiences a consistent qualifying midyear event and applies within the timely notification period of the event. For more information, please review the manual section on Qualifying Midyear Events.

Newly Eligible Employees with Other Health Benefits Coverage
Sometimes a newly eligible employee is provided continued health benefits by a previous employer for a limited period of time. The new employee may waive TLC coverage initially and postpone enrollment in the TLC Health Benefits Program until the other coverage terminates. This is considered a Special Enrollment under HIPAA. For additional information on HIPAA Special Enrollments, please refer to the manual section on HIPAA Special Enrollments.

Newly Eligible Employees with Incapacitated Children over Age 26
If a newly eligible employee wishes to enroll an incapacitated child over age 26 in the health care plan, all of the following conditions must be met:

- The employee must provide evidence that he/she or the other parent has provided coverage for the dependent from the onset of the disability.
- The onset of the disability must have occurred before the end of the year in which the child became age 26.
- The plan must approve the condition as disabling.
- The employee must apply to enroll the child within 30 days of first becoming eligible, or within 60 days of the date the child is no longer eligible to be covered by the other parent's plan as a QME (HIPAA Special Enrollment).

Additional Administrative Information

Section 12.2: Open Enrollment

Open Enrollment occurs for a two-week period in May for July groups and in August for October renewal groups. During this period employees may change health benefits plans or type of membership (including enrolling in Employee Plus One or Family membership, or waiving coverage).

It is highly recommended that all TLC groups conduct an annual Open Enrollment. **Outside of Open Enrollment, changes will not be permitted without a Qualifying Mid-Year Event.**

Elections made during Open Enrollment become effective July 1 (or October 1 for certain school groups).

Prior to the Open Enrollment period, the employer should order enrollment materials using the Materials Order Form found at www.thelocalchoice.virginia.gov. For assistance with the Materials Order Form you may contact your Anthem or Regional HMO representative. Please allow at least 10 working days for receipt of your materials.

The Group Benefits Administrator should distribute these materials to all eligible employees prior to the first day of the Open Enrollment period. Make sure that all participants are notified of the actions they may take during Open Enrollment, including all active employees and all retirees (non-Medicare eligible and Medicare eligible).

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). See the Eligibility Section of the Member Handbook for a list of applicable documentation needed.

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.

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.

Note: Inspira Financial will administer the Open Enrollment process for all COBRA participants. The COBRA participant will receive a notification regarding open enrollment changes from Inspira Financial.

Additional Administrative Information

Section 12.3: Renewals

Under The Local Choice Health Benefits Program (TLC), local employer groups renew on July 1 or October 1 (for certain school groups) of each calendar year.

Your group's renewal is an opportunity to evaluate your healthcare plan. You will receive your group's renewal during the February/March timeframe. Your vendor account representative will explain any changes to your benefits and premiums and help you compare the plans offered through TLC.

Regulations Governing the Local Choice Program
The section of the Virginia Administrative Code governing TLC program can be found at https://law.lis.virginia.gov/admincode/title1/agency55/chapter20/section20/.

Renewal Acceptance
To renew your coverage with TLC, you must submit the Employer Data Sheet through the Cardinal HCM on-line portal.

Detailed instructions for the on-line portal will be provided by the Department of Human Resource Management (DHRM) via an E-News communication to designated employer group contacts. DHRM must receive the completed Employer Data Sheet for all groups via the on-line portal by the date determined by DHRM. You will NOT be allowed to request an extension.

Termination of Group Participation in TLC
For information on termination, please reference 1 VAC 55-20-160, 1 VAC 55-20-290 and 1 VAC 55-20-300 of the Virginia Administrative Code. According to these regulations, if you choose to terminate participation in the TLC Program, DHRM must receive written notification at least 90 days prior to the date of termination. The department will notify a terminating local employer of any Adverse Experience Adjustment (AEA) within six calendar months of the time the local employer terminates participation in the program.

See the Group Withdrawal & Adverse Experience Adjustment (AEA) Determination section of this manual for more information.

Additional Administrative Information

Section 12.4: Communications

The Department of human Resource Management (DHRM) provides communications and educational materials to help employees better understand their benefits and program rules. The Local Choice (TLC) communications such as TLC E-News and Sequential Memos are posted on the TLC website under the Group Benefits Administrators link and are distributed by e-mail to persons listed as the Group Contacts.

Policies, plan information, communications, forms, and more are found on the TLC website. Visit http://www.thelocalchoice.virginia.gov/ and save as one of your favorite websites. Be sure to visit often for the latest TLC communications, including the TLC E-News and the latest version of forms.

Sequential Memos act as updates to the Local Administrators Manual (LAM). All memos are distributed through email (TLC E-News) and can be found on the TLC website and incorporated into the LAM to ensure that you have current information on the program.

How to change your Group Contact

Use the TLC Group Data Change Form to request group contact changes. Updates are generally made the first week of the month following receipt of the form. Up to 4 contacts may be listed per group. If you need to share with more persons in your group, check with your email administrator to see if an email rule can be set-up to share the messages from TLC with others.

The contacts listed on the TLC Group Data Change Form are sent to our vendors to notify them of the appropriate HR professionals that they are authorized to communicate with regarding health benefit related issues. These contacts will also receive TLC communications as noted above.

The Group Data Change Form can be found on the TLC website under the Group Benefit Administrators link.

Cardinal HCM TLC Locality User Access

Locality User Access is designated for human resource and benefits professionals who are responsible for administration of business processes for their locality, and Employee Self-Service (ESS) users. Cardinal Locality Access must be requested on the Cardinal Security Locality Access Form (Cardinal SE-LOCALITY-001) and submitted by the Virginia Department of Human Resource Management's (DHRM) Cardinal Security Officer (CSO) to the Cardinal.Security@doa.virginia.gov mailbox.

- Forms must be submitted to TLC@dhrm.virginia.gov before the CSO submits form to Cardinal Security.
- Forms will be returned to the CSO if information required is not complete or correct.
- Email notifications regarding the creation of new Cardinal Locality user accounts, and/or updates to those accounts, will be sent directly to the user and the CSO.

Please reference the Cardinal Locality Security Handbook as a reference when requesting **Cardinal system access**. Requesting Locality Access

- In order to establish a Cardinal account, please retrieve the current version of the Cardinal Security Locality Access Form (Cardinal Form SE-LOCALITY-001) from the Cardinal Project website at http://www.cardinalproject.virginia.gov/security).
- The DHRM Cardinal Security Officer (CSO) submits the Cardinal Security Locality Access Form (Cardinal Form SE-LOCALITY-001) to the Cardinal Security Team at the following email address (cardinal.security@doa.virginia.gov) to have the account created.

Cardinal Security Form

The completed Cardinal Security Form must be reviewed and approved by the DHRM Cardinal Security Officer (CSO). The form should include required signatures prior to submitting to the Cardinal Security Team, in order for access to be granted in Cardinal. The Cardinal Security Form (SE-LOCALITY-001) can be found on the Cardinal website at www.cardinalproject.virginia.gov.

Benefits Administration (BN) is the functional area containing the processes required for maintaining health and other benefits for the employees of the organization and their dependents. Benefits includes the following processes:

- TLC Plan Selection/Details (Datasheet)
- Administer Event Maintenance
- Affordable Care Act (ACA) Reporting

Descriptive Role Name	Role Description & Other Role Considerations
Benefits Administrator V_BN_ADMINISTRATOR	This role has access to: • View/update/process benefits enrollments • Run BN, HR reports and queries • View HR Data • Input and reconcile ACA data • View and update employee dependent data • Update agency BN administrator contacts

HBO Benefits Support V_BN_HBO_Support	This role has access to: • Input and reconcile ACA data • View only access to benefits data including COBRA • Run BN reports and queries Recommend assigning this role to users in centrally managed Health Benefits Only(HBO) agencies, or Centralized Localities **Buddy Role:** HR Read Only

Descriptive Role Name	Role Description & Other Role Considerations	Segregation of Duties (SOD) / Restricted Roles (RR)	Additional Approvals Required
TLC Datasheet Administrator V_BN_TLC_DATASHEET_ADMIN	This role has access to: • View/Update renewal elections (datasheet) • Run select Benefits reports • Run datasheet queries	**RR:** This role may only be assigned to employees of the following agency/division(s): **Locality users (LOCAL Business Unit)**	N/A
TLC Datasheet Administrator Read Only V_BN_TLC_DATASHEET_ADMIN_RO	This role has access to: • View renewal elections (datasheet)	**RR:** This role may only be assigned to employees of the following agency/division(s): **Locality users (LOCAL Business Unit)**	N/A

Human Resources User Roles

Human Resources (HR) is the functional area containing all employee human resource data related to the employee lifecycle. HR includes the following processes:

- Set Up and Maintain Employee HR Data

Descriptive Role Name	Role Description & Other Role Considerations	Segregation of Duties (SOD) / Restricted Roles (RR)	Additional Approvals Required
HBO HR Administrator V_HR_HBO_ADMINISTRATOR	This role has access to: • View position data • Enter/Update personal data • Enter/Update job data • Employee Match Search • Run HR reports and queries	**RR:** This role may only be assigned to employees of the following agency/division(s): **Health Benefits Only agencies or Decentralized Localities or OHB resources processing on behalf of centrally managed HBO agencies and localities.**	N/A
HR Read Only V_HR_RO	This role has access to: • View personal data • View job data • View position data • Run HR reports and queries	N/A	N/A

Listed as Group Contact but not receiving TLC communications

Group contacts should check their e-mail rules to be sure messages from TLC are permitted. Sometimes the e-mails are found in Junk or Spam folders. Your e-mail administrator should be notified if you are listed as a group contact and are not receiving TLC communications.

Additional Administrative Information

Section 12.5: Audits

Audits

Local Employer Groups will be subject to periodic audits, from both The Local Choice (TLC) and the IRS, to measure compliance with plan rules and regulations including but not limited to HIPAA. Eligibility of employees, dependents and retirees may also be reviewed.

We recommend that documentation be obtained to determine both dependent eligibility and the nature of any qualifying events that permit a change.

Local Administrative Manual

Section 13 Information & Assistance for Group Benefits Administrators

Information & Assistance

Section 13.1: Information & Assistance for Group Benefits Administrators

The Local Choice Health Benefits Program (TLC) is administered by the Department of Human Resource Management. The Department of Human Resource Management (DHRM) provides this Local Administrators Manual (LAM) to support Group Benefits Administrators.

Additionally, the Programs' Web site http://www.thelocalchoice.virginia.gov contains a full library of information on the TLC Health Benefits Programs.

Who to Contact – Group Benefits Administrators

ENROLLMENT & ELIGIBILITY
TLC@dhrm.virginia.gov or 888-642-4414

- Group Administrators should use this mailbox for all enrollment applications, changes & eligibility questions.

BILLING – Group and Direct Bill Questions

- Anthem: 800-552-2682 or TLC-COVAMembershipinquiries@anthem.com or EmployerAccess@Anthem.com
- Kaiser Permanente (HMO): 800-777-7902
- Sentara Health (HMO): 866-846-2682

Who to Contact – Group Benefits Administrators & Members

CLAIMS or COVERED SERVICES Questions

- Anthem: 800-552-2682
- Delta Dental: 888-335-8296
- Kaiser Permanente (HMO): 800-777-7902
- Sentara Health (HMO): 866-846-2682

INFORMATION & FORMS
www.thelocalchoice.virginia.gov
www.anthem.com/tlc

Local Administrative Manual

Section 14 Forms

Forms

Section 14.1: How Forms Are Processed

Form	Where to Submit	Reason
Enrollment Form	Send completed forms to TLC. Email: tlc@dhrm.virginia.gov	Enrollment/changes
Group Adjustment Form	Send completed forms to TLC. Email: tlc@dhrm.virginia.gov	Terminate a member's coverage
TLC Group Data Change Form	Send completed forms to TLC. Email: tlc@dhrm.virginia.gov	Change group's contact information
Personal Data Change Form	Send completed forms to TLC. Email: tlc@dhrm.virginia.gov	Change a participant's name, address, phone, email, etc.
Anthem Materials Order Form	www.tlcorders.com	Enrollment Forms/Provider Directory/Member Handbooks, etc. (all participating plans)
Delta Dental Order Form	Found at www.thelocalchoice.virginia.gov	
Kaiser Materials Order Form	Contact Kaiser to order materials	Order Provider Directory, PCP Form
Sentara Health Materials Order Form	Found at www.thelocalchoice.virginia.gov Submit to covamaterials@optimahealth.com	Order Benefits Brochures & Flyers
Appeal Form	Director of DHRM	Appeal to Director of DHRM once plan appeals exhausted

Additionally, there is a wealth of information available at the TLC website located at www.thelocalchoice.virgnia.gov with links to the individual carrier websites.

Forms

Section 14.2: Enrollment Form Instructions

Enrollment Forms
The main source of enrollment information about your employees and their covered family members comes from their health care coverage Enrollment Forms. It is very important that the forms are filled out accurately and completely. To ensure coverage for new members and dependents, submit the completed Enrollment Form within 30 days after an employee or family member becomes eligible.

Submitting this information as early as possible helps the health plan issue ID cards to your employees by their effective date and will ensure timely enrollment and billing.

When are Enrollment Forms required?
The Enrollment Form can be found at www.thelocalchoice.virginia.gov. Deadlines and effective dates are explained on Page 1 of the form.

All Enrollment Forms for newly eligible members must be signed and submitted within 30 days of the member becoming eligible for coverage.

An Enrollment Form signed by the employee and a group benefits administrator is required when an employee is:

- Initially enrolling
- waiving coverage
- changing status (moving from active to retiree)
- adding dependents (spouse or child)
- removing dependents (spouse or child)

This includes, but is not limited to:

- enrolling in the plan
- choosing coverage at a later open enrollment or because an event has occurred which allows enrollment other than during open enrollment
- adding a newborn
- adding a stepchild
- adding an adopted child or child placed for adoption
- adding children previously covered by other health care coverage
- adding a spouse due to marriage or if the spouse loses other coverage
- returning from military service
- removing dependents

Preparing applications for submission
Accurate and complete Enrollment Forms are essential to helping your employees' enrollment proceed quickly and smoothly.
Enrollment Forms consist of 5 Parts: Parts 1-4 must be completed and signed by the employee, retiree, survivor or Extended Coverage/COBRA Qualified Beneficiary.

Part 1: Certification and Authorization of the Person Submitting this Election Request.
This section must be completed and signed by the employee, retiree, or survivor.

Part 2: Reason for Submitting this Election Request
Indicate the reason for submitting this election request.

Part 3: Identification of the Person Submitting this Election Request
This section must be completed and signed by the employee, retiree, survivor or Extended Coverage beneficiary. Includes name, DOB, Social Security or health plan ID, address/contact information and work status.

Part 4: Health Care Coverage Election Request
In this section, employees check if they wish to waive coverage, are enrolled in other health care coverage and must list each person they want covered under the health plan.

- To waive coverage und the TLC plan, check Part 4A.
- To be enrolled in TLC coverage, check Part 4B and the plan of your choice. List all persons to be covered and include a relationship code for each person.

TLC Tip: Part 4B of Enrollment Form
Regardless of reason for submitting a new Enrollment Form, employees MUST list all persons to be covered, including the participant, with a relationship code for each one. **Do not list a person if they are to be removed from coverage.**

Part 5: Certification and Authorization of the Benefits Administrator for this Election
Must be completed by the Group Benefits Administrator. Be sure to fill in all the information.

Below are the steps you should take to ensure that your employees' applications are ready to be submitted.

Review the information provided by your employees on the application, checking items such as:
- completeness and accuracy of all parts of the Enrollment Form
- the effective date of coverage (typically, the first day of the month for which the application is accepted)
- any prior or present coverage in which the employee is enrolled (Part 4A)
- employee's signature and the date (Part 1)

Be sure each Part is complete and submit only pages 3 & 4.

Do not include supporting documentation or a TLC Group Adjustment Form. Keep the supporting documentation in your files in the event of an audit.

Use the TLC fax number or regular mail as the most secure way of submitting forms to TLC. Forms received by email are also accepted.

TLC Tip: How do I know if the Enrollment Form has been processed?
Most changes are entered into Cardinal HCM and transferred to the plan administrators within 1 – 2 business days of receipt. Sometimes it takes the plan administrator an additional day or so to update their systems.

All changes entered in Cardinal HCM are reported on the *Cardinal Enrollment Report* and the *Benefits Enrollment Changes Report*. These reports are the official record of enrollment changes.