Overview

The following is a general description of the Commonwealth of Virginia’s State Health Benefits Program eligibility and enrollment information for employees. It is not intended to replace member handbooks and other plan documents. For more detailed information or clarification, visit the DHRM website at www.dhrm.virginia.gov or contact your Benefits Administrator. Participation in the State Health Benefits Program is subject to current program provisions, state and federal laws and regulations, and plan availability. The Commonwealth reserves the right to change your enrollment to ensure compliance.

When Can I Request Enrollment or Election Changes?

When Newly Eligible

For health care coverage and flexible spending accounts, request enrollment within 30 calendar days of the date of hire or of becoming eligible. When adding dependents to coverage, supporting documentation is required that provides proof of eligibility. If you do not have the documentation, do not miss the enrollment deadline. The documents can be submitted later. See your agency Benefits Administrator.

During Open Enrollment

The Open Enrollment period occurs each spring and is your annual opportunity to enroll or make election changes to health care coverage and to enroll in FSAs effective July 1. When adding dependents to coverage, supporting documentation is required that provides proof of eligibility. If you do not have the documentation, do not miss the enrollment deadline. The documents can be submitted later. See your agency Benefits Administrator.

Qualifying Mid-Year Events

Certain qualifying mid-year events permit specific election changes outside the Open Enrollment period, including changes to your plan and membership. Examples of qualifying mid-year events include changes in your employment, changes in your marital status, changes in the number of your eligible family members, and changes affecting the employment of a covered family member. Your change request must be received within 60 calendar days of the event and be on account of and consistent with the event. You will be asked to provide supporting documentation for the qualifying mid-year event. A complete list of qualifying mid-year events may be found on the DHRM website and on the attached enrollment form. When adding dependents to coverage, supporting documentation is required that provides proof of eligibility. If you do not have the documentation, do not miss the enrollment deadline. The documents can be submitted later. See your agency Benefits Administrator.

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, under a HIPAA Special Enrollment you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stopped contributing towards your or your dependents’ other coverage). However, you must request enrollment within 60 calendar days after your or your dependents’ other coverage ends (or after the employer stops contributing toward the other coverage). In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 60 calendar days after the marriage, birth, adoption or placement for adoption.

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

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

To request a HIPAA Special Enrollment or obtain more information, contact your agency’s Benefits Administrator.
Eligibility Definitions and Required Documentation

<table>
<thead>
<tr>
<th>Dependents</th>
<th>Eligibility Definition</th>
<th>Documentation Required</th>
</tr>
</thead>
<tbody>
<tr>
<td>Spouse</td>
<td>The marriage must be recognized as legal in the Commonwealth of Virginia.</td>
<td>• Photocopy of marriage certificate, and</td>
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<td></td>
<td><strong>Note: Ex-spouses will not be eligible, even with a court order.</strong></td>
<td>• Photocopy of the top portion of the first page of the employee’s most recent Federal Tax Return that shows the dependent listed as “Spouse.” <strong>Note:</strong> All financial information and Social Security Numbers can be redacted.</td>
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<tr>
<td>Natural or Adopted Son/</td>
<td>A son or daughter may be covered to the end of the year in which he or she turns age 26</td>
<td>• Photocopy of birth certificate or legal adoptive agreement showing employee’s name. (Note: If this is a legal pre-adoptive agreement, it must be reviewed and approved by the Office of Health Benefits.)</td>
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<tr>
<td>Daughter</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Stepson or Stepdaughter</td>
<td>A stepson or stepdaughter may be covered to the end of the year in which he or she turns age 26</td>
<td>• Photocopy of birth certificate or adoption agreement showing the name of the employee’s spouse; and</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Photocopy of marriage certificate showing the employee and dependent parent’s name and</td>
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<tr>
<td></td>
<td></td>
<td>• Photocopy of the most recent Federal Tax Return that shows the dependent’s parent listed as “Spouse.” <strong>Note:</strong> All financial information and Social Security Numbers can be redacted.</td>
</tr>
<tr>
<td>Other Female or Male Child</td>
<td>An unmarried child in which a court has ordered the employee (and/or the employee’s legal spouse) to assume sole permanent custody may be covered until the end of the year in which he or she turns age 26 if:</td>
<td>• Photocopy of birth certificate and</td>
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<td>• the principal place of residence is with the employee;</td>
<td>• Photocopy of the Final Court Order granting permanent custody with presiding judge’s signature.</td>
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<td></td>
<td>• they are a member of the employee’s household;</td>
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<td></td>
<td>• they receive over one-half of their support from the employee and</td>
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<tr>
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<td>• the custody was awarded prior to the child’s 18th birthday.</td>
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</tbody>
</table>
State Health Benefits Program Enrollment Form For Employees

Review each section and carefully PRINT your enrollment information.

Section 1: Personal Information

Name: ___________________________ Identification Number: ___________________________
Last Name: ___________________ First Name: __________________ M.I.: __________________
Assigned ID or Social Security Number: ___________________________
Date of Birth: ___________________________ Gender: □ Male □ Female
Month: ______ Day: ______ Year: ______

Important! Be sure to verify the correct format of your address at http://zip4.usps.com/zip4/welcome.jsp.

Street Address: ____________________________________________________________
P.O. Box: ___________________________
City: ___________________________ State: __________________ Zip + 4: ___________________________

State E-mail: ___________________________ Personal E-mail: ___________________________

State Phone: ( _________ ) __________________ Personal Phone: ( _________ ) __________________
□ Mobile

Section 2: Reason For This Enrollment or Election Change Request

Please check one box.

☐ Open Enrollment (56)
☐ Initial Enrollment for Newly Eligible Employee: ___________________________ (01)

☐ Qualifying Mid-Year Event/Documentation to Support Eligibility

Check the type of event below, and attach the appropriate supporting documentation as indicated. Date of Event: ___________________________.

Events consistent with adding family members to coverage:

☐ Marriage (marriage certificate and current tax return) (07)
☐ Birth or Adoption (birth certificate/hospital announcement or adoption agreement) (15)
☐ Judgment, Decree, or Order to Add Child (court order) (71)
☐ Lost eligibility Under Governmental Plan (government documentation) (76)
☐ Lost eligibility Under Medicare or Medicaid (government documentation) (09)
☐ Spouse or Child Lost Eligibility Under Their Employers Plan (employer documentation) (13)

Events consistent with removing family members from coverage:

☐ Divorce (divorce decree) (10)
☐ Death of Spouse (documentation validating death) (08)
☐ Death of Child (documentation validating death) (17)
☐ Child Covered Under Plan Lost Eligibility (documentation to support) (38)
☐ Judgment, Decree or Order to Remove Child (court order) (67)
☐ Gained Eligibility Under Medicare or Medicaid (government documentation) (66)
☐ Spouse or Child Gained Eligibility Under Their Employers Plan (employer documentation) (28)

☐ Add to existing Family Membership (documentation to support eligibility) (19)

*The numbers in parentheses are for agency use

Section 3: Flexible Spending Accounts Election

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

☐ I do not wish to participate in an FSA.

HEALTH FLEXIBLE SPENDING ACCOUNT

For eligible medical expenses incurred by you, your spouse and eligible dependents. (Minimum is $10 per pay period; Maximum allowable contribution is up to $2,500.)

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

DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT

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

Amount per regular paycheck
(Whole dollar amounts only) = __________________
Section 4: Health Care Coverage Election

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

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

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

STATEWIDE HEALTH PLANS

☐ COVA Care (with preventive dental) (ACCO)
☐ COVA Care + Out of Network (ACC1)
☐ COVA Care + Expanded Dental (ACC2)
☐ COVA Care + Out of Network and Expanded Dental (ACC3)
☐ COVA Care + Expanded Dental + Vision & Hearing (ACC4)
☐ COVA HealthAware (with preventive dental) (CHA)
☐ COVA HealthAware + Expanded Dental (CHA2)
☐ COVA HealthAware + Expanded Dental & Vision (CHA1)
☐ COVA HDHP: High Deductible Plan (with preventive dental) (CHD)
☐ COVA HDHP: High Deductible Plan + Expanded Dental (CHD1)
☐ TRICARE Supplement
☒ DEERS # ____________________________________ (required)

REGIONAL HEALTH PLAN

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

Please check one box.

☐ I wish to cover the following eligible family members listed below. You will be required to submit documentation when adding family members to your coverage. Any family member not listed will not be covered.

☐ I do not wish to cover any family members.

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

<table>
<thead>
<tr>
<th>RELATIONSHIP CODE</th>
<th>LAST NAME</th>
<th>FIRST NAME</th>
<th>MIDDLE INITIAL</th>
<th>DATE OF BIRTH MM/DD/YYYY</th>
<th>SOCIAL SECURITY NUMBER</th>
</tr>
</thead>
<tbody>
<tr>
<td>Spouse</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Children</td>
<td></td>
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</tbody>
</table>

Section 5: Employee Certification and Authorization

I certify that I have reviewed and understand the State Health Benefits Program eligibility and enrollment information and I agree to abide by all participation requirements. I certify that all dependents listed meet the eligibility requirements of the program and that the information I have provided on this form is complete and accurate to the best of my knowledge. I understand that intentionally giving incorrect information is considered perjury and punishable to the fullest extent of the law. I understand that the health plan and its business associates have the right to use protected health information in connection with the treatment, payment and health plan operations allowed for by HIPAA.

Print Your Name __________________________________________ Assigned ID or Social Security Number __________________

Sign Here __________________________________________ Date ______________________________________

Section 6: Agency Verification and Approval

Date Received ___________________________ Date Keyed ___________________________ BES Effective Date ___________________________

Month/Day/Year        Month/Day/Year        Month/Day/Year

Print Contact Name __________________________________________ Phone __________________________ Agency/Group Number __________/__________

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