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

It is the Benefits Administrator's responsibility to see that each newly eligible employee receives complete and timely health and flexible 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 use EmployeeDirect for the first time.

The timeliness of completing the enrollment process is also critical. The enrollment deadlines described below apply to both health benefits and Flexible Reimbursement Account enrollment.

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 a health plan and/or flexible reimbursement accounts (FRA) offered by the state. 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 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.

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, 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 60-days of the event. For more information, please review the manual section on: "Qualifying Midyear Events."

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 State coverage initially and postpone enrollment in the State 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: "Qualifying Midyear Events."

4. 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).

5. Flexible Reimbursement Accounts (FRAs) require initial and annual enrollment

A newly eligible employee may enroll in either or both of the Flexible Reimbursement Accounts (FRAs): Medical Reimbursement Account and/or Dependent Care Reimbursement Account. The FRA enrollment must occur within 30 days of becoming eligible. There is no requirement that an employee be enrolled in health benefits to enroll in a reimbursement account.

While health benefits enrollment doesn't generally require annual re-enrollment, the FRAs require re-enrollment each year during the annual open enrollment period. Please refer to the Flexible Reimbursement Accounts Program section for additional information on the Medical and Dependent Care Reimbursement Accounts.

6. **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 and flexible reimbursement accounts.

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

Employees with an eligibility (BES) begin date of June 1 can make:
- An election for coverage effective June 1, and/or
- An election, within the 30 day enrollment period, for coverage effective July 1. The agency must submit this election request to the Office of Health Benefits for keying assistance.

Be sure when the newly eligible employee's request includes an FRA election, the employee understands that accounts with a May or June effective date end on June 30.

Steps to Enroll Newly Eligible Employees:

When a newly eligible employee wants to enroll in health benefits and/or Flexible Reimbursement Accounts, as a Benefits Administrator, you will need to take the following steps:

1. Ensure that the employee is newly eligible for benefits in the State Health Benefits Program. 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. (Name of section needed) 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. Take special care to verify whether or not the employee is a transferring employee (see step number 2 below).

2. Determine if the employee transferred from another agency with less than a 30-day break in service. If so, the employee must remain in the current health benefits plan and membership and FRA elections. (NOTE: One exception to this rule is that an employee moving in or out of his current plan's service

area may make a plan change or waive coverage as a QME.) A new enrollment action will not be necessary unless an approved election change is made.
Be sure to obtain from (or provide to) to the new agency:

- A copy of the Benefits Eligibility System (BES) record and
- The most recent Enrollment Form

The agency of record in the Benefits Eligibility System (BES) on the first day of the month is responsible for health care premiums for that month.

Example 1: A transferring employee ends employment with Agency A on April 10 and begins employment with Agency B on April 21. Health care is provided by Agency A for the month of April and coverage with Agency B will begin on May 1.

Example 2: A transferring employee ends employment with Agency C on January 31 and begins employment with Agency D on February 1. Health care with Agency C ends on January 31 and coverage with Agency D is effective February 1.

3. Give the employee complete information about the health benefits plans, types of membership, and cost of coverage. You may direct them to the DHRM Web site for the most current information regarding the State Health Benefits Program. The address is http://www.dhrm.virginia.gov.

   Explain that health care premiums will be collected through payroll deduction on a pre-tax basis. In most instances, summer premiums for faculty members, who are on pay schedules other than 24, at colleges and universities are incorporated into the premiums they pay during other months of the year.

4. Advise the part-time employee (classified staff and faculty members) who enrolls in health care coverage that the State does not provide a contribution for part-time health care benefits. Part-time employees are responsible for paying the total premium. Refer to Plan Costs in the manual section entitled (need chapter name).

5. Advise the employee of the Flexible Reimbursement Account (FRA) eligibility rules and provide details on both the Medical and Dependent Care Reimbursement Accounts. The DHRM Web site at http://www.dhrm.virginia.gov has current information on the FRA Program.

6. Inform the employee about EmployeeDirect. Once a new employee has an employment record in the Personnel Management Information System (PMIS), a “waived” record is created in the Benefits Eligibility System (BES). Agencies not using PMIS must create and keep up-to-date a BES record for the employee.

   Once the initial record is established, the employee can use EmployeeDirect to enroll and to make enrollment changes. EmployeeDirect automatically updates BES.

   If the employee enrolls by completing an Enrollment Form, establish the employee’s benefit election in BES as soon as the completed form is received. Retain the Enrollment Form in your agency file.

   Information entered into BES 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; the FRA plan administrator may access updated files on the 10th and 25th of the month.

7. Advise the employee that when requested he or she must provide coordination of benefits information each year to the medical carrier to ensure proper claim payments.

8. If the employee submits an Enrollment Form, check to see that the employee fills in the form completely and accurately. Always check the Social Security number on the form with the employee’s Social Security card to make certain it is correct.

   If a spouse and/or dependents are covered, you must obtain the required eligibility documentation based on the dependent’s relationship. Refer to the Eligibility Requirements in the section on (XX) of this manual. The information is also available on the DHRM website at www.dhrm.virginia.gov

   If a spouse and/or dependents are covered, make certain their Social Security numbers are listed. Employees can only cover a person as a 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.

   For more information on enrolling these dependent refer to the heading Enrolling Dependents Without Social Security Numbers in this section.

9. 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.

10. 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 he notes an error on the cards.

11. Provide a HIPAA Privacy Notice and an Extended Coverage General Notice, appropriately addressed, within 90 days of the commencement of coverage. Please refer to (need chapter name) of this manual for more information about the HIPAA Privacy Notice, and (need chapter name) in this manual for more information about Extended Coverage.

12. See the Commonwealth's Accounting Policies and Procedures (CAPP) manual for payroll deduction instructions.

13. Once an employee has submitted an election (either through EmployeeDirect or using 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 midyear event.

Enrolling Dependents without Social Security Numbers

Employees are generally required to provide Social Security numbers for their eligible dependents when they enroll. There are two specific situations when a SSN is not available for an eligible dependent.

1. Enrolling Newborns

Newborns may be temporarily added to the BES system by using 999-99-9999 in place of their pending Social Security Number (system will assign a random "9xx" number). However, after 90 days, the continued use of a "9xx" Social Security Number will freeze the record, preventing any future changes until an actual Social Security Number is provided. Social Security Numbers for newborns are automatically generated based on paperwork submitted by the hospital at birth.

Once the permanent number has been obtained for a newborn, the employee must submit the information to the Benefits Administrator and BES must be updated accordingly.

2. Dependents who are Foreign Nationals/Aliens:

Alien/non-citizen dependents who may not be able to provide a Social Security Number, 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 Social Security Numbers.

The Social Security Administration can provide a letter of denial to those not eligible for a Social Security number (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 BES system. The dependents are assigned a random ID number in the place of a Social Security Number (the BES system will assign a random "8xx" number). Use of the "8xx" series will allow for future changes to the record. The Department of Human Resource Management must enter all "8xx" series identification numbers.