Commonwealth of Virginia
Department of Human Resource Management

State Health Benefits Program

Active Employee Eligibility and Enrollment Form

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. The countdown begins on the day of the event. Once you have submitted a valid election during this enrollment window and that election takes effect, it is binding and may not be changed. 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. The countdown begins on the day of the event. Once you have submitted a valid election during this enrollment window and that election takes effect, it is binding and may not be changed. 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 stops contributing towards your or your dependents' other coverage). However, you must request enrollment within 60 days of the day 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 days after the marriage, birth, adoption or placement for adoption.

The Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) created two new Special Enrollment rights for certain eligible employees and dependents who lose coverage or become eligible for premium assistance under a Medicaid or state children's health insurance program. Employees must request coverage changes within 60 days of the eligibility determination.

To request a *HIPAA Special Enrollment* or obtain more information, contact your agency's Benefits Administrator.

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What Election Choices are Available?

Health Care Coverage in most cases includes medical, dental, pharmacy, and behavioral health services. Certain family members who meet eligibility and rules requirements may also be covered. Supporting documentation must be provided before family members can be added.

- Employees who enroll or fail to remove a family member who is not eligible for coverage may face disciplinary action and removal from the State Health Benefits Program for up to three years.
- Continued coverage is available for you and covered family members who lose eligibility under the State Health Benefits Program unless you enroll in the TRICARE supplement. More information about Extended Coverage (COBRA) is available on the DHRM website or from your Benefits Administrator. Portability information for the TRICARE supplement is available from the plan administrator.
- Health Care Premiums are subject to change every July 1.
- Payroll-deducted premiums are withheld on a pre-tax basis.
- Employees are obligated to pay for any month of health care coverage already begun.
- Failure to pay the premium owed results in cancellation of coverage and forfeiture of any partial payment.

Flexible Spending Accounts allow you to set aside part of your salary each pay period before taxes for eligible medical or dependent care expenses. There is a monthly pre-tax administrative fee for one or both accounts. For more information, visit the DHRM website or contact your agency Benefits Administrator.

- A flexible spending account must only be used to pay for IRS-qualified expenses and only for IRS-eligible dependents.
- Enrollees must exhaust all other sources of reimbursement (including those provided under an employer's plans) before seeking reimbursement from a flexible spending account. They may not seek reimbursement through any other source.
- Enrollees must collect and maintain sufficient documentation to validate reimbursement from a flexible spending account.

Eligibility Definitions and Required Documentation

Dependents	Eligibility Definition	Documentation Required
Spouse	The marriage must be recognized as legal in the Commonwealth of Virginia. **Note: Ex-spouses will not be eligible, even with a court order.**	• Photocopy of certified or registered marriage certificate, **and** • 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."NOTE: All financial information and Social Security Numbers can be redacted.
Natural or Adopted Son/ Daughter	A son or daughter may be covered to the end of the year in which he or she turns age 26.	• 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.)
Stepson or Stepdaughter	A stepson or stepdaughter may be covered to the end of the year in which he or she turns age 26.	• Photocopy of birth certificate (or adoption agreement) showing the name of the employee's spouse; **and** • Photocopy of marriage certificate showing the employee and dependent parent's name and • Photocopy of the most recent Federal Tax Return that shows the dependent's parent listed as "Spouse." NOTE: All financial information and Social Security Numbers can be redacted.
Other Female or Male Child	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: • the principal place of residence is with the employee; • they are a member of the employee's household; • they receive over one-half of their support from the employee and • the custody was awarded prior to the child's 18th birthday.	• Photocopy of the Final Court Order granting permanent custody with presiding judge's signature.

State Health Benefits Program Enrollment Form For Employees

Review each section and carefully PRINT your enrollment information. For state health benefits eligibility information, visit the DHRM website at www.dhrm.virginia.gov or contact your Benefits Administrator.

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

Check the box that applies. The numbers in parentheses are for agency use.

☐ **Open Enrollment** (56)

☐ **Initial Enrollment for Newly Eligible Employee:** _____ (01)
MONTH/DAY/YEAR

☐ **Qualifying Mid-Year Event/*Documentation to Support the Event***

Check the type of event below, and attach the appropriate supporting documentation as indicated. Date of Event: _____
MONTH/DAY/YEAR

Events consistent with adding family members to coverage:

☐ Marriage (certified marriage certificate) (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)

Other events:

☐ Employment Change: ☐ Full-time to Part-time (77) ☐ Part-time to Full-time (78)
☐ Unpaid Leave Began (49)
☐ Unpaid Leave Ended (50)
☐ Dependent Care Cost or Coverage Change (documentation from dependent care provider) (61)
☐ HIPAA Special Enrollment Due to Loss of Other Coverage (HIPAA certificate) (70)
☐ Move Affecting Eligibility for Health Care Plan (agency validates move) (05)
☐ Other Employers Open Enrollment or Plan Change (employer documentation) (62)
☐ Enrollment in a Marketplace Exchange Health Plan (Documentation of the Marketplace coverage enrollment and the effective date of coverage)

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

Section 3: Flexible Spending Accounts Election – You Must Enroll Every Plan Year

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 $2,750.)

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) = _____

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TEAR OFF AT PERFORATION

Section 4: Health Care Coverage Election

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

☐ No change to my current health plan selection and family members/membership level

(If you check either box above proceed to Section 5.)

A. Health Plan Selection – Check the box that applies

☐ No change to my current health care plan

STATEWIDE HEALTH PLANS

Administered by Anthem Blue Cross Blue Shield*

☐ 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 Care + Out of Network + Expanded Dental + Vision & Hearing (ACC5)
☐ COVA HDHP- High Deductible Plan (with preventive dental) (CHD)
☐ COVA HDHP- High Deductible Plan + Expanded Dental (CHD1)

Administered by Aetna*

☐ COVA HealthAware (with preventive dental) (CHA)
☐ COVA HealthAware + Expanded Dental (CHA2)
☐ COVA HealthAware + Expanded Dental & Vision (CHA1)

Administered by Selman & Company

☐ TRICARE Supplement (TRC)
DEERS # _____ (required)

*Anthem Pharmacy delivered by IngenioRx administers pharmacy benefits. Delta Dental administers dental benefits.

REGIONAL HEALTH PLANS

Administered by Kaiser Permanente of the Mid-Atlantic States, Inc.

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

Administered by Optima

☐ Optima Health HMO – available primarily in Hampton Roads zip codes (OH)

B. Family Members – Check the box that applies

☐ No change to my existing covered family members

☐ I do not wish to cover any family members

☐ I wish to cover the eligible family members listed below. ***(Note: you will be required to submit documentation when adding family members to your coverage.)***

RELATIONSHIP CODE**	LAST NAME	FIRST NAME	MIDDLE INITIAL	DATE OF BIRTH MM/DD/YYYY	SOCIAL SECURITY NUMBER
Spouse					
Children					

**Relationship Codes: SM=spouse male SF=spouse female S=son D=daughter SS=stepson SD=stepdaughter OF=other female child OM=other male child

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. I understand that participating in a Flexible Spending Account (FSA) is completely voluntary, and that payments from my FSA are independently reviewed for compliance with IRS regulations. I further understand that the IRS requires me to reimburse the Plan for any improper, erroneous or excess reimbursement amount that I do not resolve within the timeframe provided by the Plan. In accordance with §40.1-29(C) of the Code of Virginia, by enrolling in an FSA I specifically authorize the Commonwealth of Virginia to withhold from my paycheck on a post-tax basis such amounts as are necessary to replenish my FSA for any improper, erroneous or excess reimbursement.

Print Your Name _____ Assigned ID or Social Security Number _____

Sign Here _____ Date _____

Section 6: Agency Verification and Approval

Date Received _____ (Month/Day/Year) Date Keyed _____ (Month/Day/Year) BES Effective Date _____ (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.

TEAR OFF AT PERFORATION

2021-22 Language Assistance Statement
State Health Benefits Program

Virginia Department of HUMAN RESOURCE MANAGEMENT

The Commonwealth of Virginia's State and Local Health Benefits Programs (the "Health Plan") complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Our Nondiscrimination Notice lists the services available and how to file a complaint if you feel that the Health Plan has failed to provide these services or discriminated in another way.

ATTENTION: If you need help in the language you speak, language assistance services are available to you free of charge. Send your request for language assistance to appeals@dhrm.virginia.gov or fax to 804-786-0356.

Spanish:
ATENCIÓN: Si necesita ayuda en el idioma que habla, servicios de asistencia lingüística están a su disposición de forma gratuita. Envíe su solicitud de asistencia lenguaje para appeals@dhrm.virginia.gov~~V o por fax al 804-786-0356.

Korean:
주의 : 당신이 말하는 언어로 도움이 필요한 경우, 언어 지원 서비스를 무료로 당신에게 사용할 수 있습니다. 804-786-0356에 언어 appeals@dhrm.virginia.gov~~V하는 지원이나 팩스에 대한 요청을 보냅니다.

Vietnamese:
Chú ý: Nếu bạn cần giúp đỡ trong ngôn ngữ bạn nói, các dịch vụ hỗ trợ ngôn ngữ có sẵn cho bạn miễn phí. Gửi yêu cầu để được hỗ trợ ngôn ngữ để appeals@dhrm.virginia.gov~~V hoặc fax 804-786-0356.

Chinese:
注意：如果你需要在你講的語言幫助，語言協助服務提供給您免費。發送您的語言協助 appeals@dhrm.virginia.gov~~V或傳真至804-786-0356請求。

Arabic:
تنبيه: إذا كنت بحاجة إلى مساعدة باللغة التي تتحدثها، فإن خدمات المساعدة اللغوية متوفرة لك مجانًا.
أرسل طلبك للحصول على المساعدة اللغوية عبر البريد الإلكتروني إلى appeals@dhrm.virginia.gov
أو عبر الفاكس إلى 804-786-0356.

Persian:
توجه: اگر شما نیاز به کمک در زبان شما صحبت می کنند، خدمات کمک زبان در دسترس شما هستند رایگان می باشد. ارسال درخواست خود را برای کمک به زبان appeals@dhrm.virginia.gov~~V.0356-786-804 یا فکس به

Amharic:
አዳምጥ: አንተ የሚናገሩት ቋንቋ እርዳታ የሚፈልጉ ከሆነ ,የ ቋንቋ እርዳታ አገ ልግሎቶች ከክፍያ ነፃ ለእርስዎ የሚ ኙ ና ቸው. 804-786-0356 ቋንቋ appeals@dhrm.virginia.gov~~V እር ዳታ ወይም በ ፋክስ ጥያ ቄዎን ይላ ኩ.

Urdu:
توجہ فرمائیں: اگر آپ کو اپنی بولی جانے والی زبان میں مدد درکار ہے تو زبان میں مدد کی خدمات آپ کے لیے بالکل مفت دستیاب ہیں۔
زبان میں مدد کے لیے اپنی درخواستیں appeals@dhrm.virginia.gov پر بھیجیں یا 804-786-0356 پر فیکس کریں۔

French:
ATTENTION: Si vous avez besoin d'aide dans la langue que vous parlez, les services d'assistance linguistique sont à votre disposition gratuitement. Envoyez votre demande d'assistance linguistique pour appeals@dhrm.virginia.gov~~V ou par télécopieur au 804-786-0356.

Russian:
ВНИМАНИЕ: Если вам нужна помощь на языке вы говорите, переводческие услуги доступны бесплатно. Отправьте запрос о помощи языка к appeals@dhrm.virginia.gov~~HEAD=pobj~~V или по факсу 804-786-0356.

Hindi:
ध्यान दें: यदि आपको उस भाषा केलिए मदद की ज़रूरत है, जिस भाषा में आप बात करते हैं, तो आपके लिए भाषा सहायता सेवाएं निशुल्क में उपलब्ध हैं। भाषा की सहायता केलिए अपना अनुरोध appeals@dhrm.virginia.gov पर या फ़ैकस केलिए 804-786-0356 पर भेजें।

German:
ACHTUNG: Wenn Sie in der Sprache sprechen Sie Hilfe benötigen, die Sprache Hilfeleistungen zur Verfügung stehen Ihnen kostenlos zur Verfügung. Senden Sie Ihre Anfrage für sprachliche Unterstützung zu appeals@dhrm.virginia.gov~~V oder Fax an 804-786-0356.

Bengali:
দৃষ্টি আকর্ষণ: আপনি ভাষা আপনি কথা বলতে সাহায্য প্রয়োজন হয়, তাহলে ভাষা সহায়তা সেবা নিখরচা আপনার জন্য উপলব্ধ. appeals@dhrm.virginia.gov~~V অথবা ফ্যাক্স ভাষা সহায়তা 804-786-0356 করার জন্য আপনার অনুরোধ পাঠান.

Bassa:
Dè ɖɛ nìà kɛ dyéɖé gbo: Ɔ jŭ m̀ [Ɓàsɔ́ɔ̀-wùɖù-po-nyɔ̀] jŭ ní, nìí, à wuɖu kà kò ɖò po-poɔ̀bɛ́ìn m̀ ké gbo kpáa. Đá 804-786-0356.

Igo (Igbo):
Ntị: Ọ bụrụ na ị chọrọ enyemaka na asụsụ ị na-asụ, asụsụ aka ọrụ dị ka ị n'efu. Send gị arịrịọ maka asụsụ aka appeals@dhrm.virginia.gov~~V ma ọ bụ faksị ka 804-786-0356.

Yoruba:
Akiyesi: Ti o ba nilo iranlọwọ ninu ede ti o sọrọ, ede iranlowo iṣẹ ni o wa wa si o free ti idiyele. Fi ìbéèrè rẹ fun ede iranlowo to appeals@dhrm.virginia.gov tabi Faksi to 804-786-0356.

Filipino(Tagalog):
Pansin: Kung kailangan mo ng tulong sa wikang nagsasalita ka, serbisyo ng tulong sa wika ay magagamit sa iyo nang walang bayad. Ipadala ang iyong kahilingan para sa tulong sa wika upang appeals@dhrm.virginia.gov~~V o fax sa 804-786-0356.