VSDP/LTD Participants And The State Retiree Health Benefits Program

What do I need to do regarding my health plan coverage when I start long-term disability (LTD) under the Virginia Sickness and Disability Program (VSDP)?

Eligible employees may enroll in the State Retiree Health Benefits Program as an LTD participant within 31 days of their loss of active employee coverage (at the end of the month in which VSDP short-term disability ends). However, VSDP LTD participants must pay the full cost of their health plan coverage; their employer contribution ends. Employees on LTD are not retired, but they do observe plan provisions that are similar to retirees, and their Benefits Administrator is the Virginia Retirement System. All eligible employees must take a positive enrollment action **(including waive)** within 31 days of the date that their coverage (or eligibility for coverage) as an active employee ends by completing a *State Health Benefits Program Enrollment Form for Retirees, Survivors and LTD Participants*. The following options are available:

- LTD participants may maintain their existing (active employee) membership level.
- LTD participants may enroll in single coverage from waive status.
- LTD participants may *waive coverage (see page 3 for more information) or reduce membership, but they may not add family members (unless they experience another consistent qualifying mid-year event which would allow them to do so).
- LTD participants may make a plan change.
- LTD participants and their covered family members who are eligible for Medicare must select a Medicare-coordinating plan (Advantage 65, Advantage 65 with Dental and Vision, Advantage 65 – Medical Only, or Advantage 65 – Medical Only with Dental and Vision) since Medicare will generally become the primary payer of claims.
- LTD participants may *waive coverage to participate as a family member in the active state plan (or through another retiree group participant) and then (re)enroll in the retiree program within 31 days of losing that coverage.

If enrollment is completed within the required time frame, coverage in the retiree group will be effective the first of the month after coverage (or eligibility for

coverage) in the active employee group ends. There can be no break in state program coverage or eligibility for coverage.

How do I pay my health plan premium while on LTD?

All LTD participants who enroll in State Retiree Health Benefits Program coverage will be billed directly for their health plan premium (Anthem Blue Cross and Blue Shield for COVA Care or any Medicare-coordinating plan, Payflex for COVA HealthAware, or Kaiser for the Kaiser HMO). LTD participants enrolled in a plan administered by Anthem Blue Cross and Blue Shield may arrange for automatic deduction of their monthly premium from their bank account or other electronic payment. Contact Anthem for more information.

VSDP LTD Participants are eligible for the Health Insurance Credit Program, which is administered by the Virginia Retirement System (VRS). The Health Insurance Credit will not reduce the amount of premium billing, but beneficiaries will be reimbursed separately by the administrator (Reed) for the full amount of their credit, thereby reducing their net premium obligation.

What are the consequences if I miss a premium payment?

LTD participants are expected to pay their health plan premium within the required time frame indicated on their monthly invoice. If the premium is not paid within 31 days of its due date, coverage will be terminated. LTD participants who are terminated for non-payment of premiums will not have another opportunity to return to the program for the duration of LTD. However, they may enroll in state program coverage upon eligible re-employment or at retirement if they meet all other eligibility requirements.

Can I make changes to my health benefits during LTD?

Eligible LTD participants can enroll (if properly waived), change plans, or increase membership within 60 days of a consistent qualifying mid-year event. The 60-day window starts on the day of the event. Non-Medicare LTD participants may also change plans and/or membership at Open Enrollment. LTD participants may waive coverage based on a qualifying mid-year event that is consistent with ending their own coverage (e.g., election of coverage allowed under a spouse's employer plan) and they may return to the retiree program at a later date due to another consistent qualifying mid-year event; however, re-enrollment must take place within 60 days of the event. The effective date of coverage will be the first of the month after the timely enrollment form is received unless the enrollment action is received on the first of an eligible month, in which case the change will be effective on that date.

Membership increases due to birth, adoption, or placement for adoption must be requested within 60 days of the event. If the enrollment takes place within the 60-day window, coverage for the child will be effective on the date of the birth, adoption or placement for adoption. In cases when the LTD participant can provide documentation of existing coverage, the enrollment effective date can be prospective to the date that it is received.

LTD participants can reduce membership prospectively at any time; however, if an LTD participant's own coverage is terminated at any time during LTD for non-payment of premiums or canceled outside of Open Enrollment without a qualifying mid-year event, coverage will not be reinstated at any level for the duration of LTD.

If I waive coverage at the start of LTD, may I re-enroll at a later time?

LTD participants who waive coverage at the start of LTD may return to the program during LTD only upon the occurrence of a consistent qualifying mid-year event or at Open Enrollment (Open Enrollment applies to non-Medicare-eligible participants only). Eligible LTD participants may also enroll in the State Retiree Health Benefits Program at the time of retirement (see below).

What are my options if I retire while on LTD?

Eligible LTD participants who remain on LTD until retirement (with no break in LTD benefits prior to retirement) may enroll in retiree coverage at the time of their non-deferred retirement. Even if coverage was waived or canceled as an LTD participant, single coverage may be elected at retirement (within the required enrollment period).

If I become eligible for Medicare while on LTD, do I have to make any changes to my state health plan coverage?

LTD participants (not working) and their family members who become eligible for Medicare must select a plan that coordinates with Medicare, and Medicare becomes their primary health plan coverage (unless an End Stage Renal Disease Coordination Period applies). However, family groups will not pay a total premium that is greater than the family-level premium for the COVA Care or COVA HealthAware plan in which the non-Medicare family members are enrolled.

Retiree Fact Sheet #5, ***Medicare and the State Retiree Health Benefits Program***, describes the interaction of Medicare and the state program, and it provides a summary of available Medicare-coordinating plans. In addition, the ***Medicare Plan Options*** brochure is a resource regarding Medicare-coordinating

plan provisions. Go to the DHRM Web site at www.dhrm.virginia.gov to obtain these resources.

All Medicare-coordinating memberships are single; that is, each participant has his/her own ID number. In a dual or family group where there are both Medicare-coordinating and non-Medicare-coordinating memberships, all Medicare-eligible members will be single memberships and all non-Medicare memberships will be single, dual or family, as appropriate. This means that, while any family member is still "linked" to the LTD participant, individuals may have separate contracts and ID numbers. It is important for participants to recognize the difference in identification numbers and to submit the appropriate membership card to all medical providers for filing claims. Even though some family members under these circumstances may have an individual contract/separate ID, eligibility for family member coverage is still dependent upon the enrollment of the eligible LTD participant.

LTD participants and their covered family members turning age 65 will be notified of their Medicare-coordinating plan options approximately three months before their Medicare eligibility due to age. However, it is the responsibility of LTD participants to notify the appropriate Benefits Administrator of either their or their family members' eligibility for Medicare due to disability (prior to age 65). Failure to notify the plan of Medicare eligibility can result in retraction of claims paid in error and significant coverage deficits.

If I am eligible for Medicare at the start of LTD, but I have not enrolled, what should I do?

It is the responsibility of LTD participants and their covered family members who are eligible for Medicare to ensure enrollment in Original Medicare (Parts A and B) if they wish to maintain coverage in the State Retiree Health Benefits Program.

New LTD participants (or their participating family members) who have previously declined Medicare Part B (due to their coverage based on active employment) may request a Special Enrollment at any time during active coverage or during the eight months following the month that the active coverage ends. If enrollment occurs during the first full month after active coverage ends, Medicare Part B coverage can begin on the first day of the month in which enrollment occurs. If enrollment occurs during the remaining seven months of the Special Enrollment Period, Medicare Part B coverage begins the month after enrollment. (The Initial Enrollment Period can supersede Special Enrollment Period rights, so be sure to carefully monitor enrollment deadlines.) Contact the Social Security Administration (1-800-772-1213) for more information.

It is important for employees (and their participating family members) who are eligible for Medicare and who anticipate starting LTD to contact the Social Security Administration as soon as possible to ensure that Medicare coverage is

in place at the start of state coverage as an LTD participant. Failure of a Medicare-eligible LTD participant (including family members) to enroll in Medicare (Parts A and B) can result in reduced benefits since Medicare-coordinating plans in the State Retiree Health Benefits Program will not pay any benefits for which Medicare would normally be responsible had the participant appropriately enrolled. Also, failure to enroll in Medicare Part B within the Special Enrollment Period can result in delayed enrollment and higher Part B premium costs. For more information on Medicare enrollment, visit your local Social Security office (call 1-800-772-1213) or the Medicare Web site at www.medicare.gov or call 1-800-MEDICARE.

If I return to a modified work schedule, what will happen to my health benefits?

If the LTD participant returns to a modified working status (maintaining LTD benefits), he or she must continue to pay the full health plan premium—just as any LTD participant.

What happens if I do nothing at the start of LTD?

Starting LTD requires a positive enrollment action on the part of all new LTD participants within 31 days of the date their active coverage/eligibility ends. An LTD participant who does not wish to enroll in the State Retiree Health Benefits Program at the start of LTD may submit an Enrollment Form to waive coverage, thereby preserving future enrollment rights during LTD. **LTD participants who take no action at the start of LTD, including those who had waived their active coverage, will generally be terminated from the program and will have no enrollment rights for the duration of LTD.**

What do I need to do regarding my health plan coverage if I am rehired from LTD?

Participants who have been on LTD for less than 30 days and return to work without a break in eligibility for program coverage must return to the same health plan elections that they had before going on LTD.

Like starting LTD, rehire from LTD after 30 or more days also requires a positive enrollment action. The following enrollment guidelines:

- If the employee has maintained coverage during LTD but reduced membership, the employee may increase membership upon his or her return to work.
- If coverage has been waived or terminated during LTD, the returning employee may make an election just as if he/she were a new employee.

- If a timely election is not made upon returning to work, the employee may enroll at Open Enrollment or upon the occurrence of a consistent qualifying mid-year event.

All employees who return to work from LTD (30 or more days) should complete an Enrollment Form within 30 days of their return to work date in order to obtain active employee coverage. The 30 days begins on the first day that the employee returns to work.

If LTD ends, health plan coverage will end the last day of the month in which LTD ends. If the LTD participant is rehired with a break that extends into a new month, there will be a break in eligibility for coverage.

Example #1: LTD ends March 15; LTD health plan coverage ends March 31; LTD participant is rehired April 2 (or later). There is a break in eligibility for coverage between the end of LTD coverage (March 31) and eligibility for coverage as a new hire (May 1).

Example #2: LTD ends March 15; LTD health plan coverage ends March 31; LTD participant is rehired March 16 (or any date through April 1). Active employee coverage starts April 1—no break in eligibility.

Otherwise, active employee coverage with the agency contribution will begin as follows:

- If coverage was maintained during LTD, there was no break in eligibility for the program, and enrollment for active employee coverage is completed within 30 days of the return to work, the agency contribution* will begin the first of the month after the end of LTD.

- If coverage was waived or terminated during LTD and there is no break between the end of LTD and the re-hire, the agency contribution* will begin the first of the month after the end of LTD as long as the enrollment is completed within 30 days of the return to work.

  Example #1: Employee goes on LTD on June 8 and is covered by active coverage until June 30 under a family plan. The employee then makes a timely election to reduce coverage to single at the start of LTD coverage effective July 1. LTD ends on July 10 (more than 30 days from June 8), and the employee returns to work on July 11. LTD coverage continues until the end of July (at full cost). The employee submits an Enrollment Form on August 2 to enroll in family coverage as an active employee. Family coverage begins effective August 1 with the agency contribution.*

  Example #2: Employee goes on LTD on June 8 and is covered by active coverage until June 30 under a family plan. The employee then waives coverage for the start of LTD effective July 1. LTD ends on July 20 (more

than 30 days), and the employee returns to work on July 21. The employee submits on Enrollment Form on August 2 to enroll in family coverage as an active employee. Family coverage begins effective August 1 with the agency contribution*. If the form is received in July, the active coverage would still begin August 1 since August 1 is the first of the month after the end of LTD AND the first of the month after the rehire.

Example #3: Employee goes on LTD on June 8 and is covered by active coverage until June 30 under a family plan. LTD ends on August 10. LTD coverage ends on August 31. The employee is rehired on August 29 and submits an enrollment form on September 15. Coverage with the employer contribution begins on September 1. The break between August 10 and August 29 does not result in a break in eligibility for the program.

Example #4: Employee goes on LTD on June 8 and is covered by active coverage until June 30 under a family plan. LTD ends on August 10. LTD coverage ends on August 31. The employee is rehired on September 2 and submits on enrollment form on September 15. Coverage with the employer contribution begins on October 1. The break between August 10 and September 2 results in a break in eligibility for the month of September. (In this case, there would still be COBRA eligibility available based on the original reduction of hours event, but that will vary based on timing.) Options would be the same as those offered to a new employee.

*References to the agency contribution assume that the employee is eligible for the agency contribution (e.g., full-time classified employees).

What are my options if I am in LTD-working status?

Employees in LTD-working status are not and have not been on LTD (not working) during their current disability. They are continuing to work, but in a modified status (e.g., reduced hours or duties). Your Benefits Administrator can provide additional information regarding LTD-working status. However, participants in LTD-working status have the same health plan options as active employees, and agency contributions continue for the duration of the LTD-working period. However, once a participant begins LTD (not working), he or she may not return to LTD-working status during that disability. Consequently, return to a modified schedule or work duties will not reinstate the agency contribution, and, in that case, health benefits may continue under the LTD program at full cost to the participant.

Am I eligible for Extended Coverage (COBRA)?

Extended Coverage refers to the continuation coverage provisions of the Public Health Service Act for state and local government employers and is comparable

to Consolidated Omnibus Budget Reconciliation Act (COBRA) provisions for private employers. These provisions allow for continuation of health plan coverage after the occurrence of specific qualifying events, including reduction of hours which would include the start of LTD. However, if no coverage was in place on the day before the qualifying event, Extended Coverage need not be offered.

Extended Coverage, if appropriate, runs concurrently with coverage offered through the LTD program. While an LTD participant may, by law, choose Extended Coverage over LTD coverage, the cost of Extended Coverage includes a 2% administrative fee over and above the premium amount. In addition, Extended Coverage is limited to 18 months in duration (unless there is another qualifying event to extend coverage to 29 or 36 months). However, if the LTD participant elects coverage as a part of his or her LTD benefit, coverage may continue for the duration of LTD, and no administrative fee will apply. In addition, if an LTD participant terminates employment (e.g., resigns, takes a refund of his/her VRS contributions, ceases to be disabled under the provisions of the VSDP) prior to exhausting the full Extended Coverage period based on the original qualifying event, any remaining months of Extended Coverage may be used.* If an employee does not continue coverage at the start of LTD and does not elect Extended Coverage within the election period, no further Extended Coverage rights will be offered for the duration of the LTD period or upon termination of LTD.

*If LTD ends prior to the 18 months of Extended Coverage eligibility based on the original qualifying event (as described above), contact the Virginia Retirement System for assistance in exercising your remaining months of continuation coverage.

If I terminate employment while on LTD, do I have any continuing health benefit options?

An LTD participant who ends LTD to take an immediate service retirement may be eligible for coverage as a retiree under the State Retiree Health Benefits Program. Employees who defer retirement are not eligible to enroll in the program. Retiree Fact Sheet #2, ***Eligibility, Enrollment and Plan Choices***, addresses eligibility for the program.

LTD participants who terminate employment are no longer eligible for the Program and, unless they have remaining Extended Coverage eligibility, will cease to be covered at the end of the month in which termination of employment occurs. This includes participants who choose to take a refund of their VRS member contributions in lieu of retirement.

I am covered under a separate university-sponsored disability program that does not provide health plan coverage. Do I have access to the State Retiree Health Benefits Program?

State employees covered and determined to be disabled under university-sponsored disability programs (instead of VSDP) may enroll in the State Retiree Health Benefits Program within 31 days of their loss of active employee coverage with the employer contribution and continued accrual of service, if applicable. They may remain in the program as long as they continue to be covered under the disability plan or become otherwise eligible to participate (e.g., as an immediate, not deferred, service retiree). Employees covered under these programs will not, however, have an additional opportunity to enroll in the program beyond the initial eligibility period within 31 days of loss of active coverage. New eligibility for LTD coverage, with a break between active coverage and LTD or between two LTD cases, will not provide a separate LTD enrollment opportunity. Cases where there is a conflict between disability benefits (e.g., traditional disability plan versus university-sponsored LTD program) will be determined on an individual basis to ensure equitable opportunities for enrollment in the retiree program.

If an LTD participant dies, are survivors eligible to enroll or continue in the State Health Benefits Program?

Survivors of LTD participants have the same rights to enroll in the State Retiree Health Benefits Program as the survivors of active state employees.