BATH COUNTY SCHOOL BOARD

AGENDA ITEM: INFORMATION { } ACTION { X } CLOSED MEETING { }

SUBJECT: **SUPERINTENDENT'S REPORT - ACTION**

Consider the COVA Local (CL) Health Benefits Program

BACKGROUND: **The COVA Local Health Benefits Program proposal packet was received in December 2017, and a final binding decision to participate in the plan is due on January 15, 2018.**

Documentation is being provided so you can compare the COVA plan options with current health insurance benefits.

RECOMMENDATION: **Request a joint work session with the Board of Supervisors. Both boards must decide whether or not to participate in the COVA program.**

Sue Hirsh

From:	Justin Rider
Sent:	Thursday, December 14, 2017 10:39 AM
To:	Ashton Harrison; Sue Hirsh
Cc:	janetbryan@bathcountyva.org; Sharon Fry
Subject:	COVA Local Program Proposal Package - More Information
Attachments:	COVA Local Proposal Combined 2017-12-05 new.pdf; Current Health Insurance Plan SBC.docx; COVA Local PPO Option - FY 2019.xlsx

I have attached our current health insurance plan SBC as well as some very preliminary figures regarding the cost if everyone was to decide to take the COVA Local PPO Option and not the HDHP. All plans are offered to our groups and I assumed that buy-ups will be paid by the employee at 100%. I have just provided 3 options on the excel worksheet; however, there are numerous options that will need to be discussed before releasing to employees in the Spring. Remember that the final, binding decision must be made by January 15, 2018.

Thanks!

Justin S. Rider
Business Manager
Bath County Public Schools
(540) 839-2722 - option 3

From: Raney, Gene (DHRM) [mailto:Gene.Raney@dhrm.virginia.gov]
Sent: Tuesday, December 5, 2017 3:06 PM
To: Raney, Gene (DHRM) <Gene.Raney@dhrm.virginia.gov>
Cc: Waring, Anne (DHRM) <anne.waring@dhrm.virginia.gov>; Wilson, Sara R. (DHRM) <sara.wilson@dhrm.virginia.gov>; Brooks, Kathryn (DHRM) <Kathryn.Brooks@dhrm.virginia.gov>; Jones, Susan (DHRM) <susan.jones@dhrm.virginia.gov>; Finn, Sharon S. (DHRM) <sharon.finn@dhrm.virginia.gov>; Rozzell, Michelle (DHRM) <Michelle.Rozzell@dhrm.virginia.gov>; Farrish, Brenda (DHRM) <Brenda.Farrish@dhrm.virginia.gov>
Subject: COVA Local Program Proposal Package

December 5, 2017

Dear Prospective COVA Local Employers:

Thank you for your interest in the COVA Local Health Benefits Program. Many of you attended the first COVA Local Webinar earlier today. I hope that those of you who attended the COVA Local Webinar earlier today found it informative. Another webinar is scheduled for December 14, 2017. If you would like to attend this webinar, you may register at https://attendee.gotowebinar.com/rt/5534206347854760193

The deadline for local employers to make a final, binding decision to participate in COVA Local is **January 15, 2018.**

Here are the next steps:

- Review the COVA Local package at: http://www.dhrm.virginia.gov/healthcoverage/localoptionstateplaninformation
- Make a final, binding decision on whether your local entity wants to participate

If your local entity decides to make a final, binding commitment:

- Get approval from your local governing body, if needed
- Sign all appropriate documents (the authorized decision maker must sign the forms), then
- Return the signed documents to the Department of Human Resource Management at:

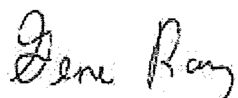
  COVA Local Health Benefits Program
  Commonwealth of Virginia
  Department of Human Resource Management
  101 North 14th Street, 13th Floor
  Richmond, Virginia 23219

All documents must be received **by 5:00 p.m. on January 15, 2018,** for a local employer to be counted as participating in the program.

A copy of the webinar slide presentation may be found at
http://www.dhrm.virginia.gov/docs/default-source/benefitsdocuments/ohb/cova-local/2017-cova-local-webinar.pdf

We appreciate your participation in this process.

Sincerely,



Gene Raney
Director, Office of Health Benefits
Department of Human Resource Management
101 N. 14th Street
Richmond, VA 23219
(804) 371-7932

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The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, https://eoc.anthem.com/eocdps/fi. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.healthcare.gov/sbc-glossary/ or call (855) 333-5735 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$1,000**/single or **$2,000**/family for In-Network Providers. **$1,500**/single or **$3,000**/family for Out-of-Network Providers.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Prescription Drugs, Preventive care, Primary Care visit, Specialist visit, and Vision exam for In-Network Providers. Prescription Drugs for Out-of-Network Providers.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	**$4,500**/single or **$9,000**/family for In-Network Providers. **$6,250**/single or **$12,500**/family for Out-of-Network Providers.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, Balance-Billing charges, and Health Care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes, KeyCare. See www.anthem.com or call (855) 333-5735 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$30/visit medical deductible does not apply	40% coinsurance	--------none--------
	Specialist visit	$50/visit medical deductible does not apply	40% coinsurance	--------none--------
	Preventive care/screening/ immunization	No charge	40% coinsurance	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	Lab – Office 20% coinsurance X-Ray – Office 20% coinsurance	Lab – Office 40% coinsurance X-Ray – Office 40% coinsurance	Lab – Office --------none-------- X-Ray – Office --------none--------
	Imaging (CT/PET scans, MRIs)	20% coinsurance	40% coinsurance	--------none--------
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at http://www.anthem.com/pharmacyinformation/	Tier1 - Typically Generic	$15/prescription pharmacy deductible does not apply (retail) and $38/prescription pharmacy deductible does not apply (home delivery)	$15/prescription pharmacy deductible does not apply (retail) and $38/prescription pharmacy deductible does not apply (home delivery)	*See Prescription Drug section
	Tier2 - Typically Preferred / Brand	$40/prescription pharmacy deductible does not apply (retail) and $100/prescription pharmacy deductible does not apply (home delivery)	$40/prescription pharmacy deductible does not apply (retail) and $100/prescription pharmacy deductible does not apply (home delivery)	
	Tier3 - Typically Non-Preferred / Specialty Drugs	$75/prescription pharmacy deductible does not apply (retail) and $188/prescription pharmacy deductible does not apply (home delivery)	$75/prescription pharmacy deductible does not apply (retail) and $188/prescription pharmacy deductible does not apply (home delivery)	
	Tier4 - Typically Specialty (brand and generic)	20% coinsurance up to $200/prescription pharmacy deductible does not apply (retail and home	20% coinsurance pharmacy deductible does not apply (retail and home delivery)	

Common Medical Event	Services You May Need	What You Will Pay: In-Network Provider (You will pay the least)	What You Will Pay: Non-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
		delivery)		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	40% coinsurance	--------none--------
	Physician/surgeon fees	20% coinsurance	40% coinsurance	
If you need immediate medical attention	Emergency room care	$150 Copay; 0% coinsurance	Covered as In-Network	--------none--------
	Emergency medical transportation	20% coinsurance	Covered as In-Network	--------none--------
	Urgent care	$30/visit medical deductible does not apply	40% coinsurance	--------none--------
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	40% coinsurance	--------none--------
	Physician/surgeon fees	20% coinsurance	40% coinsurance	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office Visit $30/visit medical deductible does not apply Other Outpatient 20% coinsurance	Office Visit 40% coinsurance Other Outpatient 40% coinsurance	Office Visit --------none-------- Other Outpatient --------none--------
	Inpatient services	20% coinsurance	40% coinsurance	--------none--------
If you are pregnant	Office visits	$30/visit medical deductible does not apply	40% coinsurance	Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.)
	Childbirth/delivery professional services	20% coinsurance	40% coinsurance	
	Childbirth/delivery facility services	20% coinsurance	40% coinsurance	
If you need help recovering or have other special health needs	Home health care	20% coinsurance	40% coinsurance	100 visits/benefit period.
	Rehabilitation services	20% coinsurance	40% coinsurance	*See Therapy Services section
	Habilitation services	20% coinsurance	40% coinsurance	
	Skilled nursing care	20% coinsurance	40% coinsurance	100 day limit/stay.
	Durable medical equipment	20% coinsurance	40% coinsurance	--------none--------
	Hospice services	No charge	40% coinsurance	--------none--------
If your child needs dental or eye care	Children's eye exam	$15/visit medical deductible does not apply	No charge up to $30/occurrence	*See Vision Services section
	Children's glasses	Not covered	Not covered	
	Children's dental check-up	Not covered	Not covered	*See Dental Services section

* For more information about limitations and exceptions, see **plan** or policy document at https://eoc.anthem.com/eocdps/fi.

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)		
• Acupuncture • Dental care (adult) • Hearing aids • Routine foot care unless you have been diagnosed with diabetes.	• Bariatric surgery • Dental Check-up • Infertility treatment • Weight loss programs	• Cosmetic surgery • Glasses for a child • Long- term care

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Abortion • Private-duty nursing Outpatient services limited to 16 hours per member per calendar year.	• Chiropractic care 30 visits/benefit period. • Routine eye care (adult) Coverage is limited to 1 screening exam	• Most coverage provided outside the United States. See www.bcbsglobalcore.com

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Department of Labor's Employee Benefits Security Administration at (866) 444-EBSA (3272) or www.dol.gov/ebsa/healthreform. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact:

ATTN: Grievances and Appeals, P.O. Box 27401, Richmond, VA 23279

Department of Labor, Employee Benefits Security Administration, (866) 444-EBSA (3272), www.dol.gov/ebsa/healthreform

Virginia Bureau of Insurance, 1300 East Main Street, P. O. Box 1157, Richmond, VA 23218, (800) 552-7945

Does this plan provide Minimum Essential Coverage? Yes

If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet the Minimum Value Standards? Yes

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

- **The plan's overall deductible** — **$1,000**
- **Specialist *copayment*** — **$50**
- **Hospital (facility) *coinsurance*** — **20%**
- **Other *coinsurance*** — **20%**

This EXAMPLE event includes services like:
Specialist office visits *(prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests *(ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	$12,840

In this example, Peg would pay:

Cost Sharing	
Deductibles	$1,000
Copayments	$212
Coinsurance	$2,006
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$3,278**

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

- **The plan's overall deductible** — **$1,000**
- **Specialist *copayment*** — **$50**
- **Hospital (facility) *coinsurance*** — **20%**
- **Other *coinsurance*** — **20%**

This EXAMPLE event includes services like:
Primary care physician office visits *(including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	$7,460

In this example, Joe would pay:

Cost Sharing	
Deductibles	$107
Copayments	$4,366
Coinsurance	$27
What isn't covered	
Limits or exclusions	$21
The total Joe would pay is	**$4,521**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

- **The plan's overall deductible** — **$1,000**
- **Specialist *copayment*** — **$50**
- **Hospital (facility) *coinsurance*** — **20%**
- **Other *coinsurance*** — **20%**

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	$2,010

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1,000
Copayments	$150
Coinsurance	$326
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,476**

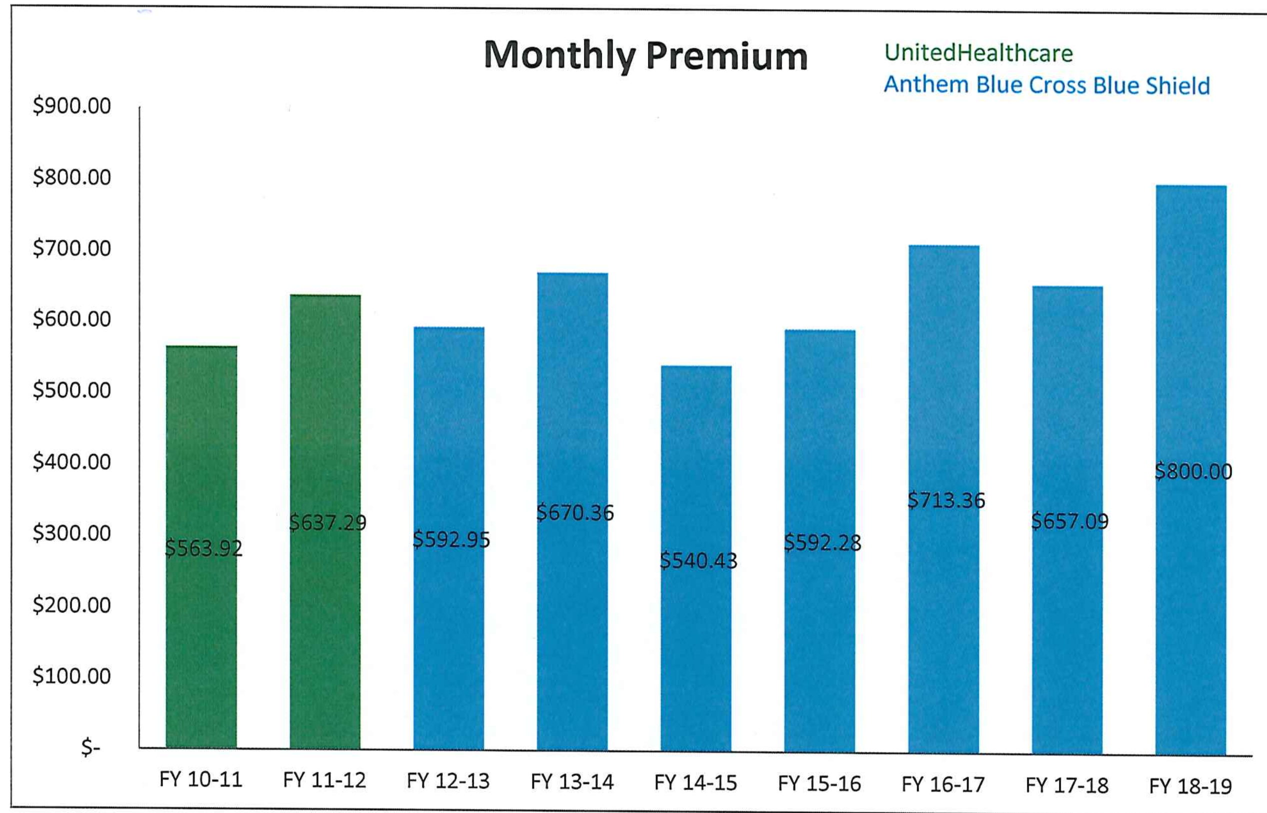
The plan would be responsible for the other costs of these EXAMPLE covered services.

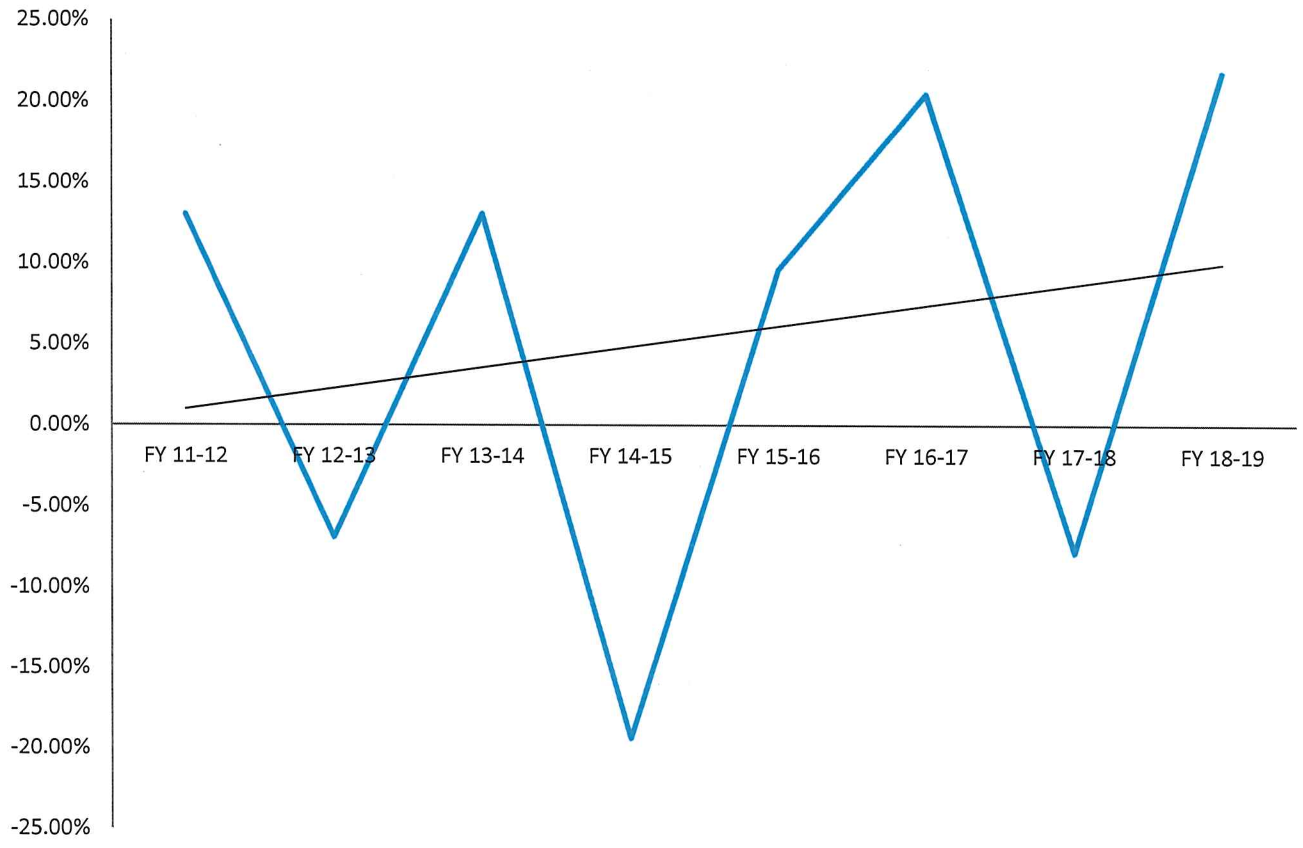
Language Access Services:

It's important we treat you fairly

That's why we follow federal civil rights laws in our health programs and activities. We don't discriminate, exclude people, or treat them differently on the basis of race, color, national origin, sex, age or disability. For people with disabilities, we offer free aids and services. For people whose primary language isn't English, we offer free language assistance services through interpreters and other written languages. Interested in these services? Call the Member Services number on your ID card for help (TTY/TDD: 711). If you think we failed to offer these services or discriminated based on race, color, national origin, age, disability, or sex, you can file a complaint, also known as a grievance. You can file a complaint with our Compliance Coordinator in writing to Compliance Coordinator, P.O. Box 27401, Mail Drop VA2002-N160, Richmond, VA 23279. Or you can file a complaint with the U.S. Department of Health and Human Services, Office for Civil Rights at 200 Independence Avenue, SW; Room 509F, HHH Building; Washington, D.C. 20201 or by calling 1-800-368- 1019 (TDD: 1- 800-537-7697) or online at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf. Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

FY 10-11	$ 563.92	
FY 11-12	$ 637.29	13.01%
FY 12-13	$ 592.95	-6.96%
FY 13-14	$ 670.36	13.06%
FY 14-15	$ 540.43	-19.38%
FY 15-16	$ 592.28	9.59%
FY 16-17	$ 713.36	20.44%
FY 17-18	$ 657.09	-7.89%
FY 18-19	$ 800.00	21.75%
Average	$ 640.85	4.96%





Percentage Change From Prior Year
25.00%
20.00%
15.00%
10.00%
5.00%
0.00%
-5.00%
-10.00%
-15.00%
-20.00%
-25.00%
FY 11-12
FY 12-13
FY 13-14
FY 14-15
FY 15-16
FY 16-17
FY 17-18
FY 18-19

Bath County School Board
2017 - 2018 Combined Health & Dental Rates - Monthly
Anthem KeyCare 30 - $1,000 Deductible

	Health		Dental		Premium		Premium			Budget	Amount as
	Employee	Employer	Employee	Employer	Percentage	Employee Total	Percentage	Employer Total	Total Premium	Category	of 12/14/17
Single	-	657.09	-	30.22	0%	-	100%	687.31	687.31	Instruction	820,753
Employee + Child	390.97	726.08	20.66	38.38	35%	411.63	65%	764.46	1,176.09	Administration	61,194
Employee + Children	390.97	726.08	32.76	60.86	35%	423.72	65%	786.95	1,210.67	Transportation	127,042
Employee + Spouse	482.84	896.69	20.66	38.38	35%	503.50	65%	935.07	1,438.57	Maintenance	87,850
Family	689.95	1,281.33	32.76	60.86	35%	722.71	65%	1,342.20	2,064.90	Technology	28,585
										Food Service	75,193

Bath County School Board
2018 - 2019 Combined Health & Dental Rates - Monthly
COVA Local PPO - $300 Deductible - Option 1 (35%/65% Split)

	Health/Dental		Current Employee	Premium		Premium			% Change	Budget	**Increase Over Amounts**
	Employee	Employer	Participation	Percentage	Employee Total	Percentage	Employer Total	Total Premium	to Employees	Category	**Above**
Single	-	800.00	92.00	0%	-	100%	800.00	800.00	-	Instruction	154,499
Employee + Child	518.00	962.00	2.00	35%	518.00	65%	962.00	1,480.00	25.84%	Administration	2,061
Employee + Children	756.00	1,404.00	7.00	35%	756.00	65%	1,404.00	2,160.00	78.42%	Transportation	16,061
Employee + Spouse	518.00	962.00	9.00	35%	518.00	65%	962.00	1,480.00	2.88%	Maintenance	12,494
Family	756.00	1,404.00	10.00	35%	756.00	65%	1,404.00	2,160.00	4.61%	Technology	2,923
										Food Service	8,855
											$ 196,893

Bath County School Board
2018 - 2019 Combined Health & Dental Rates - Monthly
COVA Local PPO - $300 Deductible - Option 2 (30%/70% Split)

	Health/Dental		Current Employee	Premium		Premium			% Change	Budget	**Increase Over Amounts**
	Employee	Employer	Participation	Percentage	Employee Total	Percentage	Employer Total	Total Premium	to Employees	Category	**Above**
Single	-	800.00	92.00	0%	-	100%	800.00	800.00	-	Instruction	176,480
Employee + Child	444.00	1,036.00	2.00	30%	444.00	70%	1,036.00	1,480.00	7.86%	Administration	6,686
Employee + Children	648.00	1,512.00	7.00	30%	648.00	70%	1,512.00	2,160.00	52.93%	Transportation	18,576
Employee + Spouse	444.00	1,036.00	9.00	30%	444.00	70%	1,036.00	1,480.00	-11.82%	Maintenance	13,382
Family	648.00	1,512.00	10.00	30%	648.00	70%	1,512.00	2,160.00	-10.34%	Technology	3,895
										Food Service	10,151
											$ 229,170

Bath County School Board
2018 - 2019 Combined Health & Dental Rates - Monthly
COVA Local PPO - $300 Deductible - Option 3 (10% Increase to Employee Cost)

	Health/Dental		Current Employee	Premium		Premium			% Change	Budget	**Increase Over Amounts**
	Employee	Employer	Participation	Percentage	Employee Total	Percentage	Employer Total	Total Premium	to Employees	Category	**Above**
Single	-	800.00	92.00	0%	-	100%	800.00	800.00	-	Instruction	175,958
Employee + Child	452.79	1,027.21	2.00	31%	452.79	69%	1,027.21	1,480.00	10.00%	Administration	45
Employee + Children	466.10	1,693.90	2.00	22%	466.10	78%	1,693.90	2,160.00	10.00%	Transportation	15,002
Employee + Spouse	553.85	926.15	2.00	37%	553.85	63%	926.15	1,480.00	10.00%	Maintenance	12,063
Family	794.98	1,365.02	2.00	37%	794.98	63%	1,365.02	2,160.00	10.00%	Technology	2,572
										Food Service	8,388
											$ 214,028

COMMONWEALTH of VIRGINIA

Sara Redding Wilson
Director

Department of Human Resource Management

101 N. 14th Street
James Monroe Building, 12th Floor
Richmond, Virginia 23219
(804) 225-2131
(TTY) 711

December 5, 2017

Dear Prospective COVA Local Employer:

Thank you for considering the COVA Local (CL) Health Benefits Program for your health insurance needs. It is a pleasure to provide our proposal for fiscal year 2019 (July 1, 2018 through June 30, 2019). CL offers two statewide plans to all employers:

- COVA Local PPO (CLP)--a Preferred Provider Organization (PPO) plan, and
- COVA Local HDHP (CLH)--a High Deductible Health Plan (HDHP) designed to be compatible with a Health Savings Account (HSA).

The self-funded CL plans include medical, basic dental, behavioral health and prescription drug coverage. The CLP and CLH plans share the same extensive Anthem provider network. In addition, the Employee Assistance Program (EAP) is offered with all plans at no extra cost, bringing further value to the program.

About the CL PLANS
Your employees may choose from among several statewide plan options. Both the CLP and the CLH plans offer:

- routine medical care and specialist care without referral requirements;
- wellness and preventive care paid by the plan at 100%;
- an outpatient prescription drug program;
- diagnostic and preventive dental care, behavioral health and EAP services; and
- BlueCard PPO® for medical care outside Virginia and Blue Cross Blue Shield Global Core for medical care outside the United States.

Medical, Behavioral Health and Prescription drug benefits for all CL plans are administered by Anthem Blue Cross and Blue Shield with dental coverage provided by Delta Dental as a subcontractor.

The CLP plans offer several buy-up options for an additional premium to enhance the employee's coverage, including:

- out-of-network coverage for medical and behavioral health services,
- expanded dental which covers primary, major and orthodontic dental care, and
- routine vision and hearing benefit which covers a routine eye exam, frames and/or lenses; and a routine hearing exam, hearing aids and other hearing aid related services.

Employees may purchase optional benefits for COVA Local PPO in these combinations:

- CLP Basic + Out-of-Network
- CLP Basic + Expanded Dental
- CLP Basic + Out-of-Network + Expanded Dental
- CLP Basic + Expanded Dental + Vision and Hearing
- CLP Basic + Out-of-Network + Expanded Dental + Vison & Hearing

The **COVA Local HDHP** is Health Savings Account (HSA)-compatible, allowing the member to set up an HSA through a bank or other financial institution. The plan includes a $1,750 individual and $3,500 family deductible with 20% member coinsurance for most benefits.

Employees may purchase optional expanded dental benefits for COVA Local HDHP by enrolling in CLH + Expanded Dental. The expanded dental option is offered for an additional premium and has a separate deductible.

We appreciate your interest in the COVA Local Plans. Additional information about COVA Local may be found at
http://www.dhrm.virginia.gov/healthcoverage/localoptionstateplaninformation
or you may call the Department of Human Resource Management Office of Health Benefits at (804) 225-3642 or toll-free at (888) 642-4414. Additionally, you may contact us by email at ohb@dhrm.virginia.gov.

Sincerely,

Gene Raney
Director, Office of Health Benefits
Department of Human Resource Management

December 5, 2017

Table of Contents

Section 1 Program Overview

- Attachment A
- Attachment B

Section 2 Comparison of Benefits

Section 3 Premium Information

Section 4 How to Enroll

- Adoption Agreement
- Explanation of Memorandum of Understanding (MOU)
- Memorandum of Understanding (MOU)

Section 1

COVA Local Plan Proposal

Program Overview

- Attachment A
- Attachment B

Program Overview

The COVA Local (CL) Health Benefits Program is an optional health benefits plan for local governments, authorities, school divisions, constitutional officers, and political subdivisions of the Commonwealth of Virginia. The program is managed by the Virginia Department of Human Resource Management (DHRM), the same team of administrators that manages the state employee health benefits program.

The CL Health Benefits Program includes the COVA Local PPO (CLP) Plan and the COVA Local HDHP (CLH) Plan.

The following plans are offered to Active Employees and Non-Medicare-Eligible Retirees.

- CLP Basic
- CLP Basic + Out-of-Network
- CLP Basic + Expanded Dental
- CLP Basic + Out-of-Network + Expanded Dental
- CLP Basic + Expanded Dental + Vision & Hearing
- CLP Basic + Out-of-Network + Expanded Dental + Vision & Hearing
- CLH
- CLH + Expanded Dental

DESCRIPTION OF PLANS OFFERED

COVA Local PPO – Statewide Plan:

Medical, Behavioral Health, Prescription Drugs, and Vision and Hearing are administered by Anthem, while Dental services are administered by Delta Dental of Virginia through a subcontract with Anthem. Since the current contract expires at the end of Fiscal Year 2019 (July 1, 2018 through June 30, 2019), the plan will procure a new contract effective Fiscal Year 2020 (July 1, 2019 through June 30, 2020).

Medical and Behavioral Health Services

The COVA Local PPO plan is a Preferred Provider Organization (PPO) plan that provides comprehensive medical, preventive care, wellness benefits, and immunizations. Members receive the highest level of benefits when visiting an in-network provider for medical and behavioral health services.

Specialist referrals are not required. Admission to a hospital for an inpatient stay must be approved in advance, or within 48 hours in the case of an emergency or birth of a child.

While members receive the highest level of benefits when visiting an in-network provider, the COVA Local PPO plan also offers out-of-network coverage for covered medical and behavioral health services, routine vision benefits (through Blue View Vision), and routine hearing benefits for an additional premium.

Prior authorization of benefits is not required, but is highly recommended. Members are encouraged to contact Anthem to confirm that their provider is in the network and that the service is medically necessary, and to minimize out-of-network costs.

The COVA Local PPO plan also allows for medical care when traveling outside Virginia through the Blue Card® PPO program and medical care outside the United States through the Blue Cross Blue Shield Global Core program.

Under the Employee Assistance Program (EAP), members receive up to four visits per issue per plan year at no cost. The EAP is only available in-network through Anthem. Prior to receiving EAP services, members should contact Anthem to verify that their provider is in the network.

Outpatient Prescription Drug Benefits

The COVA Local plan has a mandatory generic drug program administered by Anthem. 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 drug. There are no exceptions for a brand name drug when a generic equivalent is available.

Prescription drugs are divided into four copayment tiers, depending upon the type of drug:

Drug Tiers	Type of Drugs	Copay Amounts
First Tier	Typically generic drugs	$15 copay for up to a 34 day supply
Second Tier	Typically lower cost brand drugs	$30 copay for up to a 34 day supply
Third Tier	Higher cost brand drugs	$45 copay for up to a 34 day supply
Fourth Tier	Specialty drugs	$55 copay for up to a 34 day supply

Home Delivery is also available through the outpatient prescription drug benefit. Members can receive up to a 90-day supply through the mail at two times the copay of a 34-day supply.

Dental Services

All COVA Local Plans include routine diagnostic & preventive dental services. Each employee may add expanded dental coverage to include primary, major and orthodontic dental care for an additional premium.

Although members are not required to use an in-network provider for dental, they pay less when using an in-network dentist. Non-network providers may balance bill members for charges in excess of the negotiated discounts.

COVA LOCAL HDHP – Statewide Plan:

Medical, Behavioral Health, Prescription Drugs, and Vision and Hearing are administered by Anthem, while Dental services are administered by Delta Dental of Virginia through a subcontract with Anthem. Since the current contract expires at the end of Fiscal Year 2019 (July 1, 2018 through June 30, 2019), the plan will procure a new contract effective Fiscal Year 2020 (July 1, 2019 through June 30, 2020).

The COVA Local HDHP is a High Deductible Health Plan (HDHP) that includes medical, behavioral health and EAP, prescription drugs, and dental benefits. There is a separate deductible for the dental benefits.

Preventive medical care is covered with no deductible or coinsurance. All other covered medical, behavioral health, and prescription services are subject to the $1,750 employee and $3,500 family plan year deductible and 80/20 coinsurance.

Employees have the same opportunity to purchase expanded dental coverage under the COVA Local HDHP Plan as the COVA Local PPO Plan. There is a separate deductible for the expanded dental benefits.

Out-of-Network Coverage is not available.

The COVA Local HDHP is a Health Savings Account (HSA)-compatible plan. Since COVA Local does not provide the HSA, members may establish and fund their own HSA.

Eligibility for Coverage under a COVA Local PPO plan or the COVA Local HDHP plan is only for:

- Active Employees and their eligible Dependents (regardless of Medicare status)
- Non-Medicare-Eligible Retirees and their Non-Medicare Eligible Dependents

Which Medicare-Eligible individuals are not eligible to enroll or remain in a COVA Local Plan?

- Medicare- Eligible Retirees
- Medicare-Eligible Dependents of any retiree

No Pre-existing Condition Exclusions

There are no pre-existing condition exclusions in any COVA Local health plan.

VALUE ADDED BENEFITS

CommonHealth

The CommonHealth Wellness Program is a value-added benefit included for COVA Local groups. Since wellness programs often can help control claims costs, we encourage you to take advantage of all that CommonHealth has to offer. Employees and their dependents covered by any COVA Local program are eligible to participate.

LiveHealth Online.com

Use a smartphone, tablet or computer to see a board-certified doctor in minutes – anytime, day or night. LiveHealth Online is a fast and easy way to get medical care for common medical conditions like the flu, colds, allergies, sinus infections, and more. The cost is the same as a Primary Care Physician (PCP) visit.

Employee Assistance Program (EAP)

The EAP provides up to four counseling sessions per issue free of charge to covered participants and all immediate family members living in the home. A behavioral health provider will determine the number of sessions (up to four) that is appropriate for a member's care. If additional treatment is required or condition severity calls for more complex care, the member will be transitioned into the behavioral health program for which copayments are required.

Future Moms

Future Moms is a prenatal program available at no cost to covered participants. This program is designed to help women have healthy pregnancies and to help reduce the chances of a premature delivery. A nurse consultant works with the mother-to-be and her physician during the pregnancy to determine what may be needed to help achieve a full-term delivery. As soon as pregnancy is confirmed, members should sign up for the program by calling 1-800-828-5891.

Although available in all COVA Local plans, only the COVA Local PPO Plans waive the hospital copayment if the expectant mother enrolls in the Future Moms program within the first 16 weeks of pregnancy and satisfactorily completes the entire maternity management program.

Once the baby is born, members can take advantage of online visits with a certified lactation consultant, counselor or registered dietician at no extra cost through LiveHealth Online. This program helps members take advantage of personalized support to help with breastfeeding techniques, learn about baby hunger cues, foods to avoid, and more.

ADMINISTRATIVE RULES

Employer Participation Requirements

1. The COVA Local Plan requires minimum enrollment of 5,000 employees and 10,000 total lives to be implemented.

2. Employers shall participate for three consecutive years starting with the year that they join the COVA Local plan. This requirement is known as the initial commitment period.

3. Participating employers shall comply with all applicable Affordable Care Act (ACA) requirements.

4. Participating employers are precluded from offering any health benefits coverage to employees other than the COVA Local products, with the exception that employers may offer “Dental Only” or “Vision Only” plans to their employees that do not enroll in a COVA Local plan.

5. Only employers that participated in the entire preliminary approval process and elect to join by January 15, 2018 will be allowed to participate in FY 2019 (July 1, 2018 through June 30, 2019).

6. Starting with the second year of the plan, employers may initially join at any time during a given plan year. Employers that join after July 1 of a given plan year will have a short plan year for the first year. In this event, the short plan year will count as their first year of participation in the plan.

Eligibility

A. <u>Active Employees</u>

1. Employers will have significant discretion in defining “full-time employee” and “part-time employee” for purposes of defining eligibility. Employees must work at least 20 hours per week to be eligible for coverage. All employees who work at least 30 hours per week or otherwise qualify as a full-time employee under the ACA must be defined as a full-time employee.

2. Employers may choose to offer health benefits coverage to their elected officials, regardless of the number of hours that the elected officials work; however, an elected official who receives coverage and who works at least 30 hours per week or otherwise qualifies as a full-time employee under the ACA must be defined as a full-time employee. An employer must decide at renewal (or prior to open enrollment for the FY 2019 plan year), whether to offer coverage to elected officials, and a Board Resolution is required for an employer’s elected officials to receive coverage. Employers are responsible for enforcing eligibility rules for their participants.

B. **Non-Medicare Retirees, Non-Medicare Survivors, and Non-Medicare Long Term Disability (LTD) Participants**

1. New COVA Local employers have the opportunity to offer coverage to Non-Medicare Retirees, Survivors, and LTD Participants upon initial enrollment in the COVA Local Program. During a subsequent renewal period, they may then choose to discontinue any of these benefits at the start of the following plan year, and existing participants will be terminated at that time. Employers who decide not to offer these benefits upon initial enrollment will have one opportunity to offer coverage at the start of any subsequent plan year if they do so during the relevant renewal period. Once any employer offers and then discontinues any of these benefits, they will not have another opportunity to do so again in the future. Specific eligibility provisions for Non-Medicare Retirees, Non-Medicare Survivors, and Non-Medicare LTD participants may be found in Attachment A ("COVA Local Eligibility Criteria for Non-Medicare Retirees, Survivors, and LTD Participants") of this document.

2. COVA Local will not offer Medicare supplemental coverage. Thus, Medicare retirees and Medicare-eligible dependents of any retiree shall not be eligible for coverage. If Medicare eligible individuals are incorrectly enrolled in COVA Local, any claims costs paid to the Medicare-eligible individuals will be borne by the employer, including prescription drug costs.

Plan Provisions

1. Each plan year will run from July 1 to June 30. For example, the plan year beginning July 1, 2018 will end on June 30, 2019.

2. COVA Local does not include a Total Population Health Program. This may be re-evaluated at a later date once the plan has more experience.

3. Employers shall offer all available plan options to all eligible employees.

4. COVA Local plans will follow plan design rules of corresponding state employee health plans as closely as possible. To provide for accurate premium rate setting and sufficient communications, there may be times when the changes made to COVA Local occur the year after corresponding changes have been made in the state employee health plan.

5. The COVA Local plan provisions shall apply the same rules regarding dependent eligibility; however, each employer may opt at initial enrollment to exclude coverage for spouses who have access to minimum essential health benefits (as defined by the Affordable Care Act (ACA) through their own employer. During a subsequent renewal period, the employer may then choose to include this coverage for this category of dependent at the start of the following plan year. Employers who decide to offer these benefits upon initial enrollment will have one opportunity to cease this coverage at the start of any subsequent plan year if they do so during the relevant renewal period. Once any employer offers and then discontinues this coverage, they will not have another opportunity to do so again in the future.

6. The COVA Local plan provisions shall apply the same rules regarding initial and annual enrollment periods, and the events that would allow an election change outside of the annual enrollment period (QMEs) as those that apply to the State Employee Health Benefits program. Specific information may be found in Attachment B ("COVA Local Dependent Eligibility, Enrollment and Changes") of this document. Any participating employer that has an existing Cafeteria Plan document shall ensure that their document complies with the COVA Local plan provisions and make any current and future needed amendments.

7. Open enrollment for the FY 2019 (July 1, 2018 through June 30, 2019) is planned to occur during April and May 2018.

8. Responsibility for claims paid in error due to failure of an employer to enforce eligibility rules or to timely terminate a participant due to non-payment of premiums will be borne by the employer.

Underwriting Requirements

1. All employers will be part of a single rating pool.

2. Employers leaving the plan at any time will be subject to an Adverse Experience Adjustment (AEA) if the claims experience of the total pool has exceeded the premiums. The AEA will be determined using a 3 year lookback period, and will represent the employer's portion of any pool deficit during the lookback period. The employer's portion of the deficit shall be determined by its pro rata share of the pool's experience. The plan's actuaries shall monitor and determine any adverse experience adjustment.

3. During year two and three of the plan, rate increases will be capped at the actuarially-determined trend for the state employee health plan plus 3%. The actuarially determined trend is defined as the change in per capita health care costs due to the health care inflation and changes in utilization.

4. To participate in the COVA Local plan, an employer must meet a minimum participation requirement of 70% for active employees. If an employer does not meet the minimum participation requirement, then the employer will not be able to participate in the next plan year. This rule supersedes the initial commitment period rule listed above.

5. Employers must make a minimum employer contribution of 75% of the basic plan's ("COVA Local PPO Basic" or "COVA Local HDHP Basic") "Employee Only" premium for full-time employees; and for part-time employees, employers must make a minimum employer contribution of 50% of the amount paid for full-time employees. For example, if an employer makes an employer contribution of 80% for full-time employees, then it must make an employer contribution of at least 40% for part-time employees. No employer contribution is required for dependents or retirees.

6. The COVA Local plan will have stop-loss protection based on the size of the pool.

Billing

1. All billing is group billed. Employers shall collect premiums from all of their enrollees, regardless of employee status, and pay total group premium to the billing agent designated by the Department of Human Resource Management (DHRM).

ACA Reporting

1. DHRM shall provide ACA reporting for an employer if the employer has participated in COVA Local or a combination of COVA Local and The Local Choice (TLC) health plan for the entire calendar year. The employer must provide written authorization for DHRM to do the reporting, and provide all information that DHRM requests in a timely manner and in the required format.

2. DHRM will provide COVA Local-related data to employers that participated in a COVA Local plan for a partial calendar year which they may use in preparing their own reports.

ADDITIONAL INFORMATION

More information is available in the Comparison of Benefits document found later in this package.

If you have questions about eligibility or policy administration, please contact the DHRM Office of Health Benefits at (804) 225-3642 or toll-free at (888) 642-4414. You may also send inquiries by e-mail to ohb@dhrm.virginia.gov

Visit the COVA Local Health Plan Information web page at http://www.dhrm.virginia.gov/healthcoverage/localoptionstateplaninformation for more extensive information about the program.

Attachment A

COVA Local Eligibility Criteria for Non-Medicare Retirees, Survivors, and LTD Participants

Issued November 30, 2017

New COVA Local employers have the opportunity to offer coverage to Non-Medicare Retirees, Survivors and LTD Participants upon initial enrollment in the COVA Local Program. During a subsequent renewal period, they may then choose to discontinue any of these benefits at the start of the following plan year, and existing participants will be terminated at that time. Employers who decide not to offer these benefits upon initial enrollment will have one opportunity to offer coverage at the start of any subsequent plan year if they do so during the relevant renewal period. Once any employer offers and then discontinues any of these benefits, they will not have another opportunity to do so again in the future.

NON-MEDICARE RETIREES

COVA Local employers can opt to newly offer or continue offering coverage to Non-Medicare Retirees effective July 1, 2018, based on the eligibility criteria provided below. Any employer that currently offers Non-Medicare Retiree coverage may move existing Non-Medicare Retirees to COVA Local coverage as long as they are otherwise eligible based on DHRM policy. However, coverage for newly-eligible Non-Medicare Retirees will be available only on a prospective basis.

The following eligibility criteria must be met:

- The employee must be eligible for coverage as an active employee (not including Extended Coverage) at the time of termination (last day of coverage as an active employee);
- The employee must enroll within 31 days of the termination/retirement date.

For employers that offer a defined benefit plan (DBP):

- The terminating DBP employee must be eligible for and take an immediate retirement benefit from their COVA Local employer's defined benefit retirement plan.

For employers that also offer a defined contribution plan (DCP):

- The terminating DCP employee must meet the age and service requirements of the COVA Local employer's defined contribution plan (no distribution required).

- If the COVA Local employer offers only a DCP, the terminating employee must meet the age and service requirements of the Virginia Retirement System's defined contribution plan for state employees.

Coverage will continue based on the policies of the Department of Human Resource Management, including coverage of family members based on the same eligibility criteria as those for active employee family members.

NON-MEDICARE SURVIVORS

COVA Local employers can opt to newly offer or continue offering coverage to Non-Medicare Survivors effective July 1, 2018, based on the eligibility criteria provided below. Any employer that currently offers Non-Medicare Survivor coverage may move existing Non-Medicare Survivors to COVA Local coverage as long as they are otherwise eligible based on DHRM policy. However, coverage for newly-eligible Non-Medicare Survivors will be available only on a prospective basis.

Regardless of an employer's decision to offer continuing Survivor coverage, covered family members of active COVA Local employees will be covered until the end of the month after the month in which the covered employee dies, including receiving the employer premium contribution. The membership level may not be changed during the additional month of coverage.

Coverage for surviving family members of retirees or LTD participants will terminate at the end of the month in which the retiree or LTD participant's death occurs (no additional month of coverage).

Non-Annuitant Survivors

For COVA Local employers who decide to offer coverage for Survivors effective July 1, 2018, any family member who is covered at the time of the employee's or retiree's death may continue health plan coverage if they enroll within 60 days of the employee's or retiree's death, regardless of their Survivor annuity status.

Non-annuitant surviving spouses may be covered until remarriage, obtaining alternate health insurance coverage, or death. Non-annuitant surviving children may be covered until the end of the year in which they turn age 26, and if they meet the eligibility criteria for an adult incapacitated dependent, they may be covered after age 26 until they are no longer incapacitated. Additional family members (those not covered at the time of the employee's/retiree's death) may not be added as non-annuitant survivors.

Annuitant Survivors

If applicable, survivors of employees and retirees who are eligible for and take an immediate survivor benefit from the COVA Local employer's defined benefit retirement plan are eligible to enroll in Survivor coverage if they do so within 60 days of the employee's or retiree's death. This is not contingent upon existing enrollment at the

time of the death as long as the employee or retiree was enrolled in coverage at the time of death. Depending on the specifics of each employer's retirement options, this may not be available to employees/retirees of all employers (e.g., employers that only offer a defined contribution retirement plan). Survivors who opt to take a lump sum survivor benefit are not eligible to enroll as a Survivor (unless they qualify as a non-annuitant).

After enrollment, an annuitant surviving spouse can maintain coverage during his or her lifetime, but eligibility limits apply to dependent children of the surviving spouse. An annuitant surviving spouse can add dependents based on the program's eligibility criteria, including a legal spouse. However, upon the death of an annuitant surviving spouse, covered dependents will lose coverage at the end of the month in which the death occurs, but they may be offered Extended Coverage for up to 36 months. (While death of a surviving dependent is not generally an Extended Coverage qualifying event, DHRM policy allows for these expanded continuation coverage criteria.) Annuitant surviving children covered without a parent may maintain coverage based on the eligibility criteria for dependent children.

Stepchildren covered at the time of the employee's/retiree's death may continue coverage based on the eligibility provisions for non-annuitant Survivors. If they are eligible dependents of an annuitant surviving spouse, they may be added to coverage with a qualifying midyear event or at open enrollment.

However, if the covered surviving spouse who is the natural or legal adoptive parent of the deceased employee's/retiree's stepchildren dies, and the children are not otherwise eligible for Survivor coverage in their own right, their eligibility is lost. Under these circumstances, the children's loss of dependent child status would be an Extended Coverage qualifying event and would require the offer of 36 months of Extended Coverage.

Upon the death of an annuitant surviving spouse of a deceased employee or retiree, a new spouse covered under his/her membership will terminate at the end of the month in which the surviving spouse's death occurs. There is no Survivor coverage available to the spouse of a Survivor. However, dependents covered on the day before the death who lose coverage due to the death may be offered Extended Coverage for 36 months per DHRM policy.

NON-MEDICARE LTD PARTICIPANTS

COVA Local employers can opt to newly offer or continue offering coverage to Non-Medicare LTD participants effective July 1, 2018, based on the eligibility criteria provided below. Any employer that currently offers Non-Medicare LTD coverage may move existing Non-Medicare LTD participants to COVA Local coverage as long as they are otherwise eligible based on DHRM policy. However, coverage for newly-eligible Non-Medicare LTD participants will be available only on a prospective basis.

Newly-eligible LTD participants and their eligible family members must enroll within 31 days of their termination from active employee coverage (or termination of eligibility for active coverage), which is generally the end of the month in which short term disability (STD) is exhausted. Increasing membership at the start of LTD coverage is not allowed unless there is a separate qualifying mid-year event that is consistent with the addition.

Coverage will continue based on the policies of the Department of Human Resource Management for active employee family members.

Attachment B

COVA Local Dependent Eligibility, Enrollment and Changes

Issued November 30, 2017

DEPENDENT ELIGIBILITY

The Following Dependents Are Eligible for Coverage Under the COVA Local Health Benefits Program

The employee must provide proof of dependent eligibility whenever a dependent is added to the health plan. If it is determined that a person is covered in error, the plan has the right to take corrective action. Dependents of non-Medicare retirees, Survivors and Long-Term Disability (LTD) participants are defined the same as dependents of "Employees."

The Employee's Legal Spouse

The marriage must be recognized as legal in the Commonwealth of Virginia. Ex-spouses are not eligible, even if there is a court order.

The Employee's Children

The following eligible children may be covered to the end of the calendar year in which they turn age 26 (the plan's limiting age). The age requirement may be waived for adult incapacitated children.

- **Natural or Adopted Children and Children Placed for Adoption**

- **Stepchildren**
  A stepchild is the natural or legally adopted child of the employee's legal spouse. Such marriage must be recognized by the Commonwealth of Virginia.

- **Other Female or Male Child**
  An "other female or male child" is an unmarried child for whom a court has issued a final order naming the employee (and/or the employee's legal spouse) as sole permanent custodian prior to the child's 18th birthday. Custody may not be shared with anyone other than the employee and the employee's legal spouse. In addition, the child must fulfill the following criteria:

  • child's principal place of residence is with the employee;
  • child is not self-supporting and relies on the employee for financial support;

  - **Exception for Grandchildren**
    If the employee (or employee's legal spouse) shares custody of their grandchild with their minor (under age 18) dependent who is the parent of the grandchild, then the grandchild may also be covered if:

- the grandchild, the minor dependent (who is the parent), and the employee's legal spouse (if applicable) all live in the same principal residence as the employee;
- both the minor dependent and the grandchild are unmarried;
- neither the minor dependent nor the grandchild are self-supporting, and they rely on the employee for financial support;
- the custody of the grandchild is not shared between anyone other than the employee, the employee's legal spouse and the minor dependent.

  The minor dependent must meet all of the eligibility requirements of a dependent child. Once the minor dependent turns 18, the employee or employee's legal spouse (if applicable) must receive sole permanent custody of the grandchild for the grandchild to remain eligible.

Incapacitated Dependents

Adult children who are incapacitated due to a physical or mental health condition may continue to be covered as long as the child was covered by the health plan and the incapacitation existed prior to the termination of coverage due to the child attaining the plan's limiting age. The employee must make written application, along with proof of incapacitation, prior to the child reaching the plan's limiting age. Such extension of coverage must be approved by the health plan and is subject to periodic review. The child must live full-time with the employee, not be married, not be self-supporting, and rely on the employee for financial support. In cases where the natural or adoptive parents are living apart, living with the other parent will satisfy the condition of living with the employee. Furthermore, the support test is met if the child is not self-supporting and relies on either the employee, the other parent, or a combination of the employee and other parent for financial support. Should the health plan find that the child no longer meets the criteria for coverage as an incapacitated child, the child's coverage will be terminated at the end of the month following notification from the health plan to the enrollee.

Who Is 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 (except as otherwise specifically covered), nieces, and nephews except where the criteria for "other children" are satisfied. Parents, grandparents, aunts, uncles, and any other individuals not specifically listed as eligible in this section are not eligible for coverage regardless of dependency status.

Employees 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. Employees who enroll or fail to remove ineligible persons may be excluded from the program for a period of up to three years. In addition, the employee will be responsible for claims paid in error and may be responsible for maintaining the existing membership level until the start of the next plan year based on IRS Section 125 requirements.

ENROLLMENT AND CHANGES

There are only certain times when the employee may enroll, add, or delete eligible dependents in a health benefits plan, or change plans. The employee must remove anyone who is no longer eligible for the plan within 60 days of losing eligibility, and the termination date will be the end of the last month during which eligibility requirements were met.

When Newly Eligible

The employee has up to 30 calendar days to enroll from their "date of hire" or the date they become eligible for health benefits. The 30-day countdown period begins on the first day of employment or eligibility. If the enrollment action is received within the 30 calendar day time frame, coverage will be effective the first of the month following the date of employment or eligibility. If that date is the first day of the month, the coverage begins that day.

During the Annual Open Enrollment

Open enrollment occurs in the spring and is the employee's opportunity to make changes in their health benefits plan and/or type of membership. The benefits and premiums associated with open enrollment elections will be effective July 1 through June 30 of the following plan year. Open Enrollment elections are irrevocable once the open enrollment period ends.

Qualifying Mid-Year Events (Changes Outside Open Enrollment)

Employees may make membership and plan changes during the plan year that are based on qualifying mid-year events. The employee must submit the change within 60 calendar days of the event. The countdown begins on the day of the event. Normally the change will be effective the first of the month after the date an election change request is received. There are two exceptions to the prospective effective date rule. These include HIPAA Special Enrollment Provision for Birth, Adoption and Placement for Adoption and terminations required by the plan which are covered later in this section. In addition, once the employee has submitted a valid election that election is binding and may not change after it takes effect. The following events permit or require a plan and/or membership change outside open enrollment, but only if the change is made on account of, and corresponds with the qualifying mid-year event:

- Birth, Adoption, or Placement for Adoption
- Child Covered under the health plan Lost Eligibility
- Death of Child
- Death of Spouse
- Divorce
- Employment Change – Beginning/Ending a Leave Without Pay
- Enroll in a Qualified Health Plan through the ACA Marketplace Exchange
- Medicare or Medicaid Entitlement
- HIPAA Special Enrollment
- Judgment, Decree, or Order to Cover a Child
- Lost Eligibility under Governmental Plan
- Marriage
- Move Affecting Eligibility for Health Care Plan
- Other Employer's Open Enrollment or Plan Change
- Spouse or Child Gained/Lost Eligibility under Their Employer's Plan

Birth, Adoption or Placement for Adoption

Employees have 60 days from the day a child is born to add the newborn to their health plan. If the child is adopted, they have 60 days from the date of adoption or placement for adoption. When the enrollment action is received by the employer within the 60-day time frame, the child will be added to health plan coverage the first of the month during which the birth, adoption or placement for adoption took place.

Terminations Required by the Plan

Terminations required by the plan due to loss of eligibility include events such as divorce or loss of a child's eligibility. In cases where there is a loss of dependent eligibility, the effective date of the change is based on the date of the event. The employee still has 60 calendar days to submit the enrollment action to remove the ineligible dependent. However, the change is effective the end of the month in which the dependent lost eligibility.

Section 2

COVA Local Plan Proposal

Comparison of Benefits

2017-18 COMPARISON OF BENEFITS - COVA LOCAL PLANS

Health Plans	**COVA Local PPO**	**COVA Local HDHP**
In-Network Benefits	**You Pay**	**You Pay**
Deductible – per plan year • One person • Two or more persons	 $300 $600	 $1,750 $3,500
Out-of-pocket expense limit – per plan year • One person • Two or more persons	 $1,500 $3,000	 $5,000 $10,000
Doctor's visits • Primary care physician • Specialist	 $25 $40	 20% after deductible 20% after deductible
Hospital Services • Inpatient • Outpatient	 $300 per stay $125 per visit	 20% after deductible 20% after deductible
Emergency Room Visits	$150 per visit (waived if admitted)	20% after deductible
Ambulance Travel	20% after deductible	20% after deductible
Outpatient diagnostic, laboratory, tests, injections and x-rays	20% after deductible	20% after deductible
Infusion services (includes IV or injected chemotherapy)	20% after deductible	20% after deductible
Outpatient therapy visits • Occupational and speech therapy • Physical therapy only • Physical therapy and other related services, including manual intervention & spinal manipulation • Chiropractic services (30-visit plan year limit per member)	 $25 PCP/$35 specialist $15 $25 PCP/$35 specialist $25 PCP/$35 specialist	 20% after deductible 20% after deductible 20% after deductible 20% after deductible
Applied behavioral analysis (ABA) for autism spectrum disorder – ages 2 through 10	$25 per service	20% after deductible
Behavioral health • Medical and non-medical behavioral visits • Inpatient residential treatment • Intensive outpatient treatment (IOP)	 $25 $300 per stay $125 per episode of care	 20% after deductible 20% after deductible 20% after deductible
Employee Assistance Program (EAP) Up to 4 visits per incident	$0	$0
Prescription drugs – mandatory generic **Retail Pharmacy** **Home Delivery Pharmacy**	 *Up to 34-day supply* *$15/$30/$45/$55* *Up to 90-day supply* *$30/$60/$90/$110*	 *Up to 34-day supply* 20% after deductible *Up to 90-day supply* 20% after deductible
Dental Services • Diagnostic and preventive	$0	$0
Annual Routine Vision Exam	Optional benefit*	Not available
Annual Routine Hearing Exam	Optional benefit*	Not available

2017-18 COMPARISON OF BENEFITS - COVA LOCAL PLANS

Health Plans	**COVA Local PPO**	**COVA Local HDHP**
In-Network Benefits	**You Pay**	**You Pay**
Wellness & preventive services	$0 • *Office visits at specified intervals, immunizations, lab and x-rays* • *Annual check-up visit (primary care physician or specialist) immunizations, lab and x-rays* • *Routine gynecological exam, Pap test, mammography screening, prostate exam (digital rectal exam), prostate specific antigen (PSA) test, and colorectal cancer screening*	$0
Expanded Dental • Maximum benefit – per member • Deductible • Primary (basic) care • Complex restorative (inlays, onlays, crowns, dentures, bridgework) • Orthodontic --Lifetime maximum benefit	**Optional Benefit*** $2,000 $50/$100/$150 20% after deductible 50% after deductible 50% no deductible $2,000	**Optional Benefit*** $2,000 $50/$100/$150 20% after deductible 50% after deductible 50% no deductible $2,000
Routine Vision (once every plan year) • Routine eye exam • Eyeglass frames • Lenses --Eyeglass lenses (*standard plastic, single, bifocal or trifocal) or* *--Contact lenses –* • Conventional** • Disposable** • Non-elective**	**Optional Benefit*** $40 80% after plan pays $100 $20 85% after plan pays $100 Balance after plan pays $100 Balance after plan pays $250	Not available Not available
Routine Hearing • Routine hearing exam (once every plan year) • Hearing aids and other hearing-aid related services (once every 48 months) • Benefit maximum	**Optional Benefit*** $40 Balance after plan pays $1,200 $1,200	Not available
Out-of-Network	**Optional Benefit*** Plan payment reduced by 25%. Balance billing may apply.	Not available except in an emergency.

*Optional benefits are offered for an additional premium, and may be purchased in combinations as shown on the monthly premiums chart. **Elective contact lenses are in lieu of eyeglass lenses. Non-elective lenses are covered when eyeglasses are not an option for vision correction.

These benefit designs are the same as the comparable state plans. This is only an overview of your health care benefits. For details, see the appropriate Member Handbook, or plan document, or visit http://www.dhrm.virginia.gov/healthcoverage/localoptionstateplaninformation.

Section 3

COVA Local Plan Proposal

Premium Information

Premium Information

COVA LOCAL (CL) FINAL MONTHLY RATES FY 2019			
CL PLAN OPTIONS	**PREMIUM TIERS**		
	EE ONLY	**EE+1**	**EE+ FAMILY**
COVA Local PPO (CLP) Basic	$800.00	$1,480.00	$2,160.00
CLP Basic + OON*	$819.00	$1,515.00	$2,211.00
CLP Basic + Expanded Dental	$827.00	$1,530.00	$2,233.00
CLP Basic + OON* + Expanded Dental	$846.00	$1,565.00	$2,284.00
CLP Basic + Expanded Dental + Vision & Hearing	$846.00	$1,565.00	$2,284.00
CLP Basic + OON* + Expanded Dental + Vision & Hearing	$865.00	$1,600.00	$2,335.00
COVA Local HDHP (CLH) Basic	$613.00	$1,134.00	$1,655.00
CLH + Expanded Dental	$640.00	$1,184.00	$1,728.00

***"Out-of-Network"**

Minimum Employer Contribution Rates

COVA LOCAL (CL) MINIMUM EMPLOYER CONTRIBUTION RATES FY 2019			
CL PLAN OPTIONS	PREMIUM TIERS		
	EE ONLY	EE+1	EE+ FAMILY
COVA Local PPO (CLP) Basic	$600.00	$600.00	$600.00
CLP Basic + OON*	$600.00	$600.00	$600.00
CLP Basic + Expanded Dental	$600.00	$600.00	$600.00
CLP Basic + OON* + Expanded Dental	$600.00	$600.00	$600.00
CLP Basic + Expanded Dental + Vision & Hearing	$600.00	$600.00	$600.00
CLP Basic + OON* + Expanded Dental + Vision & Hearing	$600.00	$600.00	$600.00
COVA Local HDHP (CLH) Basic	$460.00	$460.00	$460.00
CLH + Expanded Dental	$460.00	$460.00	$460.00

Section 4

COVA Local Plan Proposal

How to Enroll

- Adoption Agreement
- Explanation of Memorandum of Understanding (MOU)
- Memorandum of Understanding (MOU)

How to Enroll

Required Agreements

An Adoption Agreement as well as a Health Insurance Portability and Accountability Act (HIPAA) Memorandum of Understanding (MOU) must be completed by the employer to enroll in the COVA Local Program. **The completed Adoption Agreement and MOU must be received by the Department of Human Resource Management (DHRM) by January 15, 2018** for your group to be eligible to participate in the FY 2019 plan year (July 1, 2018 through June 30, 2019), which will be the inaugural year of the COVA Local Health Benefits Program. Minimum enrollment requirements must be met for the program to be implemented.

The Adoption Agreement acknowledges the rights, duties and responsibilities of DHRM and the employer. The MOU outlines responsibilities under HIPAA. Signed originals of the Adoption Agreement and MOU are required.

Print, Complete, Sign and Send your Adoption Agreement and MOU to:

COVA Local Health Benefits Program
Commonwealth of Virginia
Department of Human Resource Management
101 North 14th Street, 13th Floor
Richmond, VA 23219

If you have questions about enrolling in the COVA Local Program, you may contact the DHRM Office of Health Benefits by:

Telephone: (804) 225-3642
(888) 642-4414
Email: ohb@dhrm.virginia.gov

DHRM will return executed copies of your agreements once they are approved.

Employer Data Sheet

Groups that enroll in the program will be sent an Employer Data Sheet and enrollment packages in early 2018. The Employer Data Sheet confirms rates, eligibility and contribution levels. You will be required to complete and submit this data sheet to DHRM. The enrollment packages will include a summary of benefits for each plan being offered, enrollment instructions and an Enrollment Form.

Adoption Agreement

WHEREAS, the Department of Human Resource Management of the Commonwealth of Virginia (hereinafter referred to as the “Department”), has established the COVA Local Health Benefits Program (hereinafter referred to as the “Program”) effective July 1, 2018, and

WHEREAS, the Governor and General Assembly have approved such Program; and

WHEREAS, pursuant to §2.2-1204 of the Code of Virginia, local employers may, by making proper application and complying with the regulations governing the Program, participate in the Program; and

WHEREAS, ____ (hereinafter called the "Employer") is eligible to and authorized to participate in the Program and become a party to any agreements established to carry out the funding of the Program, and wishes to adopt said Program for the benefit of its eligible employees, and to become a party to said agreements;

NOW, THEREFORE, effective as of ______________, 20___ (today’s date), the Employer, acting herein by and through its duly authorized representatives, hereby adopts the Program for all of its eligible employees and subscribes to the provisions of the regulations and all agreements related thereto by and between the Department and any third party, effective _______________, 20____ (effective date of coverage), all in accordance with the following:

(1) The Employer agrees to comply with the rules and regulations governing the Program and the duties of Employers set forth therein. These duties include, but are not limited to, the following:

- Execute an adoption agreement;
- Remit total premiums, including employer and employee contributions, to the Department or its designee as set forth in guidance;
- Provide employees with enrollment forms, and process and certify the same;
- Serve as a channel of communication between the Department and employees;
- Otherwise assist in administration of the Program as requested by the Department.

(2) The employer agrees to be bound by all of the terms, provisions, conditions and limitations of the Program and any agreements which are pertinent to any entity defined as an "Employer" therein, with respect to its employees eligible for participation in the Program.

(3) The employer agrees to participate in the Program for three consecutive years starting with the year it joined the Program.

(4) The employer agrees to comply with all applicable Affordable Care Act (ACA) requirements.

(5) The Employer agrees that the Department shall act as Plan Administrator for the Employer and its employee-participants under the Program in the same manner in which the Department acts for state employee-participants.

(6) The Employer agrees to provide 90 days notice to the Department in the event it wishes to cease participation in the Program. The Employer shall be obligated to pay any and all contributions otherwise required through the date of termination and interest related thereto as well as any adverse experience adjustment which may apply with respect to the year the termination occurred.

(7) The Employer understands and agrees that non-payment of contributions shall be considered a breach of the adoption agreement and the employer may be obligated to pay damages. In the event that the Employer terminates participation, such termination can only be prospective and the employer shall be obligated to pay the greater of past contributions or actual claims incurred during such period and any interest and damages that may be associated with such non-payment. In no event will the Department return to the Employer contributions made for ineligible employees.

(8) The Employer agrees to furnish from time to time such information with reference to its employee participants as may be required by the Plan Administrator.

(9) The Employer agrees to reimburse the Department for costs, expenses or settlements, including the Department's reasonable attorney's fees, incurred by the Department as a result of any employee's filing a lawsuit based on the Employer's disregard of the regulations or violation of this adoption agreement.

(10) The "effective date of coverage" shall mean, in regard to the Employer and its employee participants, the date on which coverage begins for the Employer and its employee participants.

IN WITNESS WHEREOF, this agreement has been executed on behalf of the Employer, and its seal hereunto affixed by its duly authorized representatives on this day of _______________, 20___.

Attest: ___________________________ By: ____

(Witness) (Decision Maker)

It is hereby certified that the Employer is eligible to become signatory to the Health Benefits Program and that its participation in the Program has been approved.

Department of Human Resource Management: ____

Dated: ____________________ By: ____

Explanation of Memorandum of Understanding (MOU)

The Office of Health Benefits of the Department of Human Resource Management has adopted revised practices to assure the privacy and confidentiality of health information for the employees of COVA Local employers and to comply with the privacy requirements specified by the Health Insurance Portability and Accountability Act (HIPAA) of 1996. It is important that that each employee within your agency's Benefits Office knows, understands, and abides by these new practices. These practices are intended to restrict access to the health information by your benefits staff. and minimize exposure to the federal penalties and sanctions associated with the HIPAA Privacy Regulation.

HIPAA Overview

The Health Insurance Portability and Accountability Act (HIPAA) was signed into law by President Clinton on August 21, 1996. The Act was conceived to guarantee that health insurance coverage is available to workers and their families in the event of a job change or job loss. The original scope was expanded to require the Secretary of Health and Human Services (the Secretary) to include provisions for standardizing the data content and format for electronic transactions (EDI), guarantee the privacy of confidential personal health care information, and secure the physical access to records.

Title I – Health Insurance Portability

Title I protects health coverage by:

- Increasing a new hire's ability to obtain health coverage for self and dependents.
- Lowering an individual's chance of losing health care coverage through a job or through individual health insurance.
- Helping an individual maintain continuous health coverage for self and dependents in the event of a job change.
- Helping individuals buy health insurance coverage if coverage is lost under an employer's group plan.

HIPAA provides special enrollment rights that limit the use of pre-existing condition exclusions; prohibits group health plans from discriminating by denying coverage or excessively charging someone with past or present poor health, and provides special provisions to renew employer health plans.

Title II – Administrative Simplification

Privacy and security of data must be assured in an environment where employee health care data is more accessible by providers and employers; therefore, the Secretary was given the authority to create national standards to protect individuals' medical records

and other personal health information, and set boundaries on the use and release of health records by establishing safeguards that health care plans must achieve.

The regulations identify the following required procedures for the Health Plan:

- Provide information to members about their privacy rights and how their information can be used.
- Adopting clear privacy procedures.
- Training employees who work with protected information to understand privacy procedures.
- Appointing a Privacy Official responsible for assuring that the privacy procedures are adopted and followed.
- Securing protected health information (PHI) so that it is available to only those with a legitimate need to know. Personally identifiable health information (PHI) means information, in any form, that relates to:
    - (A) any physical or mental health condition of an individual;
    - (B) provisions of health care to an individual; or
    - (C) any payment for health care to an individual.

In response to the regulations, the Office of Health Benefits Programs:

- will be providing Privacy Notice and Plan Amendments for all employees eligible for the COVA Local Health Benefits Program to the employer's Benefits Office for distribution,
- has adopted and will maintain privacy procedures,
- has appointed a Privacy Official, and
- will implement procedures to secure protected health information.

In order to ensure the security of the protected health information, we recommend that all employees be directed to the Claims Administrator with all claim issues. If the employer's Benefits Office is asked to assist in the claim resolution, they must be mindful of the HIPAA privacy regulations. Benefit Administrators must have a complete understanding and abide by the HIPAA privacy policies established by the Office of Health Benefits. Additionally, employers must establish and enforce sanctions for those employees who violate these policies. For those employer contacts with an e-mail address on file, our office will forward an electronic copy of the HIPAA Privacy training information and copies of the Office of Health Benefits Privacy Policies and Procedures manual. For the employers without e-mail access, we will forward copies of the documents under separate cover.

Enclosed you will find a Memorandum of Understanding regarding the Privacy of Protected Health Information. Please sign and return this memorandum to the Office of Health Benefits by ___January 15, 2018_________________.

Memorandum of Understanding

(Privacy of Protected Health Information)

Pursuant to the Health Insurance Portability and Accountability Act (HIPAA) of 1996, and its implementing regulation, the Standards for Privacy of Individually Identifiable Health Information, 65 Fed. Reg. Section 84,462 et seq. (Dec. 28, 2000) and all subsequent provisions and Federal guidance (HIPAA Privacy Rule), The Office of Health Benefits (OHB), and employer, named on the signature page of this agreement, wish to enter into an agreement that addresses the requirements of the HIPAA Privacy Rule with respect to the employer's role in administering the health benefits plan for the group's employees.

I. This agreement is intended to ensure that the employer will establish and implement appropriate safeguards (including certain administrative requirements) for Protected Health Information (PHI) as regulated by the Secretary of Health and Human Services and outlined in the OHB HIPAA implementation package.

As used in this agreement PHI means individually identifiable health information maintained and transmitted in any form or medium, including, without limitation, all information (including demographic, medical, and financial information), data, documentation, and materials that is created or received by a health care provider, health plan, plan sponsor, employer, or health care clearinghouse, and relates to: (A) the past, present, or future physical or mental health or condition of an individual; (B) the provision of health care to an individual; or (C) the past, present, or future payment for the provision of health care to an individual, and that identifies or could reasonably be used to identify an individual.

II. The employer acknowledges and agrees that in providing administrative assistance to employees and the COVA Local Health Benefits Program,

a. The employer may, receive, use, or disclose PHI. However, the sharing of PHI is restricted to those individuals who have a need to know the information in order to assist the affected individual and the information will be maintained in the strictest of confidence.
b. When requesting, using or disclosing PHI the employer must make reasonable efforts to limit PHI to the minimum necessary to accomplish the intended purpose of the use, disclosure or request.
c. All protected information received by the employer should be secured and accessible only to benefits personnel who have been authorized to assist the employee.

III. As a member of the COVA Local program it is understood that the employee handbooks will serve as part of the COVA Local wraparound plan document for employers who participate in the program. Furthermore, the employer agrees to: (1) not use or further disclose protected health information other than as permitted or required by the plan documents or as required by law; (2) ensure that any subcontractors or agents to whom the employer provides protected health information agree to the same restrictions; (3) not use or disclose the protected health information for employment-related actions; (4) report to the group health plan any use or disclosure that is inconsistent with the plan documents or this regulation; (5) make the protected health information accessible to individuals; (6) allow individuals to amend their information; (7) provide an accounting of its disclosures; (8) make its practices

available to the Secretary of Health and Human Services for determining compliance; (9) return and destroy all protected health information when no longer needed, if feasible; and (10) ensure that the firewalls have been established between those functions required to administer the health benefits plan and all other functions conducted by the employer.

IV. The employer acknowledges that any infraction of these referenced regulations by the employer or employer's representative may result in sanctions or penalties for noncompliance. These penalties are imposed by the Office of Civil Rights (OCR), which include criminal fines and/or imprisonment. The severity of the penalties varies depending on the violation (see the implementation package for more specific information). The employer agrees that any such penalty imposed by OCR, which is resultant of any action, or inaction taken by one of their representatives, will be the responsibility of the employer.

V. The undersigned hereby agree to the provisions contained in this memorandum of understanding:

by:____ ______________
(Signature) (Date)

____
(Name)

____
(Title)

____
(Employer's Name)

by:____ ______________
(Signature) (Date)

Gene Raney
Director, Office of Health Benefits
Department of Human Resource Management

COVA LOCAL WEBINAR (2016) SB 364 CHAFIN

VIRGINIA DEPARTMENT OF HUMAN RESOURCE MANAGEMENT

December 5 and 14, 2017

COVA LOCAL
(2016 SB 364, CHAFIN)

What We'll Cover

- Plan Provisions
- Participation Requirements
- Eligibility
- Underwriting Requirements
- Billing
- ACA Reporting
- Plans
- Out-of-Pocket Expenses
- Premiums
- Interest Level
- Timeline
- Next Step

PLAN PROVISIONS

- **Plan year** runs from **July 1 through June 30** each year
- **Open Enrollment** is scheduled for **May 2018**
- **Same rules** as state plan
  - Dependent eligibility
  - Initial and annual enrollment periods
  - Events which allow election changes outside of Open Enrollment
  - New rules may have a delayed implementation

PARTICIPATION REQUIREMENTS

- **Minimum participation** of **5,000 employees and 10,000 members** needed to establish the plan
  - Fiscal Year 2019 participation limited to employers participating in the entire rollout process
- **Initial commitment** of three consecutive years
  - After FY 2019 employers may **join at any time during the plan year**
  - Employers joining after July 1 will have a **short plan year** for their first year
- **Can only offer COVA Local** to employees
  - Except for Dental and Vision for employees who do not enroll in the COVA Local plan

ELIGIBILITY

- **Employees**
  - local governments
  - schools
  - other political subdivisions eligible to participate in TLC
- **Elected officials** if eligible to participate in the entity's benefit plans
- **Eligible dependents** of those employees

ELIGIBILITY–ACTIVE EMPLOYEES

- Employers may define **"full time" and "part time"** employees within certain parameters
  - Employees must **work at least 20 hours per week**
  - Employees working **30 or more hours on average per week** must be defined as full time
  - Employers may choose to **set more expansive hourly requirements** for **full-time** employees
    - For example, may set a rule that all 20-hour/week employees are full-time
    - Must comply with the ACA

ELIGIBILITY - OPTIONS

- Employers may choose to offer **coverage**
  - **Non-Medicare retirees**
  - **Elected officials**
  - **Survivors**
  - **LTD participants**
- Employers may **NOT offer** coverage
  - Medicare-eligible retirees
  - Medicare-eligible dependents of any retiree

UNDERWRITING REQUIREMENTS

- **Self-funded,** just like the state plan
- **Single rating pool**
- **Individual stop loss** to protect against large individual claims
- **Employer responsible** for claims paid in error
  - Eligibility rules not enforced, or
  - Failure to terminate participant for non-payment
- **Minimum participation** of 70% of eligible employees
- **Minimum employer contributions**
  - **Full-time employees:** 75% of EE Only Basic premium
  - **Part-time employees:** 50% of the full-time contribution

UNDERWRITING REQUIREMENTS

- **Adverse Experience Adjustment (AEA)** if an employer leaves the plan at any time
  - Three-year **lookback period**
  - Assessed if the **claims experience** of the pool **exceeds the premiums**
  - **Pro rata portion** based on enrollment count of the pool deficit
- **Rate cap** during years two and three of the plan based on actuarially-determined **trend for the state employee health plan plus 3%**

BILLING

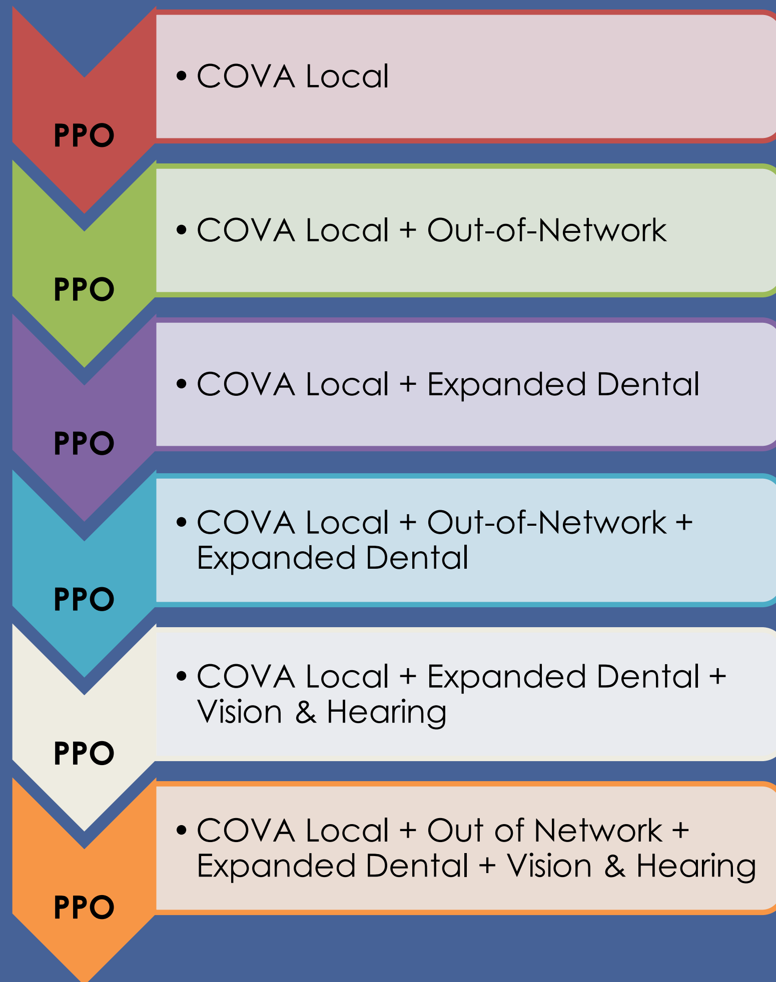
- **Group billing**
  - Employers pay the total premium to DHRM-designated billing agent

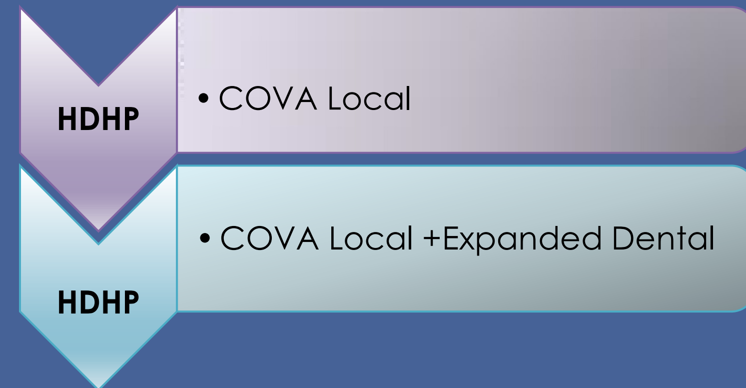
AFFORDABLE CARE ACT (ACA) REPORTING

- DHRM **will offer ACA reporting** for a calendar year provided that the employer:
  - Offers **TLC and/or COVA Local** to its employees the **entire calendar year**
  - Provides **written authorization** for DHRM to do the reporting and certifies enrollment accuracy
  - Submits all necessary information **timely and in the required format**

COVA LOCAL PLANS

- Same plans offered to state employees





OUT-OF-POCKET EXPENSES

- Same **out-of-pocket expenses** as the state employee health plan
- Plan design is constantly reviewed and is subject to change from year to year

State Out-of-Pocket Expenses - FY 2018		
Health Plan Overview In Network	**COVA Care & COVA Local PPO**	**COVA HDHP & COVA Local HDHP**
Deductible - Individual/Family	$300/$600	$1,750 / $3,500
Coinsurance	20%	20%
OOP Limit	$1,500 / $3,000	$5,000 / $10,000
PCP	$25 copay	20% after deductible
Specialist	$40 copay	20% after deductible
IP Facility	$300 copay	20% after deductible
OP Facility	$125 copay	20% after deductible
Emergency Room	$150 copay	20% after deductible
Urgent Care	$25/$40 copay	20% after deductible
Pharmacy In Network		
Generic	$15 copay	20% after deductible
Preferred Brand	$30 copay	20% after deductible
Non-Preferred Brand	$45 copay	20% after deductible
Specialty	$55 copay	20% after deductible
Mail Order Rx	2x retail	20% after deductible

PREMIUMS

- Financially viable **new multiple employer plans** typically cost more than established single employer plans
- **Single set of annual rates** for all participating entities
- **Premium rates** determined by claim experience and demographics of all interested entities

COVA LOCAL (CL) FINAL MONTHLY RATES FY 2019			
CL PLAN OPTIONS	PREMIUM TIERS		
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COVA LOCAL (CL) MINIMUM EMPLOYER CONTRIBUTION RATES FY 2019			
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COVA Local PPO (CLP) Basic	$600	$600	$600
CLP Basic + OON*	$600	$600	$600
CLP Basic + Expanded Dental	$600	$600	$600
CLP Basic + OON* + Expanded Dental	$600	$600	$600
CLP Basic + Expanded Dental + Vision & Hearing	$600	$600	$600
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COVA Local HDHP (CLH) Basic	$460	$460	$460
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COVA Local
INTEREST LEVEL

- Minimum enrollment of 5,000 employees and 10,000 members for plan to be implemented

Local Option Health Insurance Program						
	Date	# of Groups	# Eligible Employees	# Enrolled Employees	# Enrolled Dependents	# Total Enrolled Members
ROUND 1						
• **Declared NON-BINDING preliminary Interest**	11/9/2016	247	136,353	**109,510**	108,560	**218,070**
• **Submitted required data**	1/31/2017	209	125,290	**100,128**	99,394	**199,522**
ROUND 2						
• **Declared NON-BINDING preliminary Interest**	5/24/2017	101	46,250	**37,187**	33,960	**71,147**
• **Submitted required data**	9/1/2017	89	41,770	**33,519**	30,255	**63,774**
ROUND 3						
• **Declared BINDING Interest**	1/15/2018	TBD	TBD	TBD	TBD	TBD

COVA Local
TIMELINE

When	Who	What
Spring 2016	DHRM	Begin outreach to legislators and constituents
Summer 2016	DHRM	Develop program rules
August 2016	All	Conduct information webinars
September 14, 2016	Participants	Indicate preliminary interest to participate
October 14, 2016	Participants	Complete data submissions due to actuaries
January 2017	DHRM	Publish preliminary premium rates
February 2017	Participants	Indicate continuing interest in participating
August 2017	DHRM	Complete procurement if needed
November 2017	DHRM	Publish final premium rates
January 15, 2018	Participants	Make binding election to participate
May 2018	All	Conduct open enrollment
July 1, 2018	All	Go live!

NEXT STEP

- Employers indicate **final binding interest** by January 15, 2018, in order to participate the first year
- Detailed **program requirements** available

http://www.dhrm.virginia.gov/healthcoverage/localoptionstateplaninformation