

ADMINISTRATION OF DEPENDENT COVERAGE TO AGE 26 POLICY

Dependent coverage must be made available for health plans until age 26 effective July 1, 2011 for the State Group Health Insurance Plan (GHIP). As a grandfathered health plan, the GHIP may exclude adult children who are eligible to enroll in an employer-sponsored plan available through the dependent's employer until the plan year beginning July 1, 2014.

This section describes how this policy will be administered and impact payment of benefits for dependents. In order to certify that an employee's dependent who turned 21 prior to the end of the preceding calendar year is, or is not, covered by a plan where the dependent is employed, all employees who enroll for Employee & Children or Family coverage MUST complete the Dependent Verification of Employer Coverage Form:

- upon enrolling the dependent who turned 21 prior to the end of the preceding calendar year;
- during subsequent open enrollment periods; and
- within 30 days of any change to the dependent's employment which impacts their eligibility for benefits as described below.

The form must also be completed at the end of the calendar year in which an enrolled dependent turns 21.

A dependent does not need to be enrolled in the health care plan where he or she works if ONE of the following reasons is applicable:

- The dependent is less than 21 or turned 21 in the current calendar year; or
- The dependent is less than 24 and is a full-time student; or
- The dependent does not work full-time; or
- The dependent is not eligible for benefits under the employer's health care plan because they have not satisfied his or her employer's requirements as to the number of hours worked; or
- The dependent's employer requires a contribution of more than 50% of the premium for the lowest benefit plan available through his or her own employer; or
- The dependent's employer does not offer medical coverage.

**See separate notations below regarding waiting periods, open enrollment periods, and employers with HMO plans only.*

The following describes how the policy effects the benefits payment for dependents:

- If the employee **does not complete** the Dependent Verification of Employer Coverage Form as described above (upon enrolling dependent who turned 21 prior to the end of the preceding calendar year, during subsequent open enrollment periods, within 30 days of any change to the dependent's employment which impacts benefit eligibility or at the end of the calendar year in which an enrolled dependent turns 21) until July 1, 2014, the State will pay 20% of allowable charges for services covered under the State's health care plan until the Form is completed.
- If the dependent **is eligible for and not enrolled** in the health care plan offered by his or her own employer, the State will pay 20% of allowable charges for services covered under the State's health care plan.

- If the dependent **is eligible for and enrolled** in the health care plan offered by his or her own employer, the State will not pay for benefits provided under the State's health care plan until after the dependent's health care plan pays. Payment from both plans combined will not exceed 100% of covered charges.
- If the dependent **is not eligible for and, therefore, is not enrolled** in the health care plan where he or she works or any other health care plan, the State will pay for benefits as provided under the Employee's selected State health care plan.

How to Determine the 50% Contribution Requirement

When determining contributions made by the dependent's employer to his or her health care plan, all flexible benefit dollars and/or credits available to the dependent are counted as contributions provided by the dependent's employer. If these contributions are less than 50% of the premium for the lowest benefit plan available through the dependent's employer, it is not necessary for the dependent to enroll in his or her own employer's plan.

What Happens When There is a Waiting Period

The dependent's employer's plan may have an eligibility waiting period (a time period when the dependent is not eligible to enroll for benefits) or a contribution waiting period (a time period when the dependent is responsible for the cost of the health care plan). In either case, benefits will be provided under the Employee's selected State health care plan until the waiting period has been satisfied. Once the dependent has satisfied the eligibility and/or contribution waiting period, all benefits will be paid according the *Coordination of Benefits* section, unless the dependent fails to enroll under his or her employer's plan when he or she is eligible. If the dependent fails to enroll under his or her employer's plan, then benefits will be paid at 20% of the allowable charge.

What Happens When There is no Open Enrollment Period for the Dependent

Sometimes a dependent may be unable to enroll in his or her own employer's plan because there will be no Open Enrollment Period until after July 1, 2011. In such cases, benefits will be provided under the Employee's selected State health care plan until the next Open Enrollment Period for the dependent's employer plan, provided that such Open Enrollment Period occurs prior to or on June 30, 2012.

If the dependent is not enrolled in his or her own employer's plan by June 30, 2012, the State will pay benefits at 20% of the allowable charges for services covered under the Employee's selected State health care plan, until such time that the dependent obtains employer coverage.

What Happens When the Dependent's Employer Only Offers an HMO Program

Some employers may only offer an HMO program and the dependent may live outside of the HMO program service area. In such instances, it is not necessary that the dependent enroll under his or her own employer's plan. However, the State will evaluate the dependent's enrollment under the employer's plan on an annual basis, beginning July 1, 2012. If, in the judgment of the State, the dependent's employer is offered only an HMO program to avoid covering dependents of State employee, then the State reserves the right to pay benefits at 20% of the allowable charge for services covered under the Employee's selected State health care plan.

Policy Effective Date July 1, 2011