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| Health Insurance Eligibility | **Last Revision:** | November 2016 |
| **Last Reviewed:** | December 2017 |
| **Applies to the following THA Group of Companies:**  | * Island Health Care
* Island Hospice
* Independent Life at Home
* RightHealth®
* THA Services
* Palliation Choices
* Integuhealth
 |
| **Included in the following THA Manuals:** | Administration Policies & ProceduresTalent Management |

### PURPOSE

To define parameters surrounding THA Group’s health insurance eligibility.

### POLICY

**Requirements for Employee Coverage:** A person is eligible for employee coverage as of the date

that all of the following requirements are met:

1. The person is in a full-time class and is on the regular payroll of the Employer. Full-time is defined as working a minimal of 30 hours a week.
2. The person has completed the probationary period of **ninety (90) days a**s an active employee.

A “probationary period” is the time between the first day of employment and the first day of coverage under the Plan. Absences due to health reasons will be disregarded in determining whether the waiting period is satisfied. Coverage is effective on the **first day following** the waiting period. The Employer has established safe harbor measurement and stability periods to determine full-time status and eligibility for coverage in accordance with applicable law.

If an employee is considered a variable hour employee, the employer will use a twelve initial month look-back measurement period from the employee’s date of hire to evaluate if the employee would qualify as a fulltime employee after the measurement period. An employee is considered variable hour if the employer cannot determine if the employee is reasonably expected to average 30 hours of service per week because their hours vary or are otherwise uncertain.

If a variable hour employee is found to have averaged 30 hours of service during the measurement period, the employee will be considered fulltime and offered enrollment into the medical plan in accordance with applicable law.

The employee will continually be tested for fulltime status in the employer’s standard measurement period. Coverage in the medical plan will continue to be offered at the end of the stability period as the variable hour employee qualifies in accordance with applicable law.

**Requirements for Dependent Coverage:** A family member of an employee will become eligible for dependent coverage on the first day that the employee is eligible for employee coverage and the family member satisfies the requirements for dependent coverage.

Dependents eligible for coverage include:

1. The employee's spouse, of the same or opposite sex, legally married under the laws of any state. A covered employee's spouse, who is employed and eligible for coverage under his/her employer plan, must accept coverage under his/her employer plan in order to be eligible for coverage under THA Group's plan. If the spouse is not employed or their employer does not provide coverage, the spouse will be considered an eligible dependent.
2. The employee's child(ren) until the end of the month in which he or she turns the age of twenty-six (26), including:
	1. A natural born child
	2. A stepchild
	3. An adopted child or a child lawfully placed with the employee for legal adoption by the employee. A "child lawfully placed with the employee for legal adoption" refers to a child whom the employee intends to adopt, whether or not the adoption has become final, provided that the child has not attained the age of eighteen (18) as of the date of placement for adoption.
	4. An eligible foster child. An eligible foster child is an individual who is placed with the employee by an authorized placement agency or by judgment, decree or other order of any court of competent jurisdiction.
3. An employee's unmarried child over the age of twenty-six (26) who is mentally or physically incapable of earning his/her own living due to permanent, chronic and total disability. The child may obtain continued coverage if, within thirty (30) days after the date coverage would otherwise terminate, the employee submits proof of the child's incapacity (see Eligibility for Disabled Children); and
4. A minor ward for whom the employee has legal guardianship and who is primarily dependent upon the employee for support and resides with the employee.

**Note:** The phrase “primarily dependent upon” shall mean dependent upon the covered employee for support and maintenance as defined by the Internal Revenue Code, and the covered employee must declare the dependent for purposes of taking an income tax exemption. The Plan Administrator may require documentation proving dependency, including birth certificates, tax records, or initiation of legal proceedings severing parental rights.

At any time, the Plan Administrator may require documentation proving that a spouse or a child qualifies or continues to qualify as a dependent as defined by this Plan, including but not limited to marriage licenses, birth certificates, and/or a court order establishing a relationship of parent and child. If both husband and wife are employees, their children will be covered as dependents of the husband or wife, but not of both.

Any child of a Plan participant who is an alternate recipient under a Qualified Medical Child Support Order (QMCSO) shall be considered as having a right to dependent coverage under this Plan. A participant of the Plan may obtain from the Plan Administrator, without charge, a copy of the procedures governing QMCSO determinations.

**Eligibility for Disabled Children:** In order for a disabled child to be eligible for coverage under the Plan beyond the end of the month of the child’s twenty-sixth (26th) birthday, the child:

1. Must be enrolled in the Plan prior to the age of twenty-six (26).
2. Must be incapable of self-support because of mental or permanent, chronic, and total disability which commenced prior to the age of twenty-six (26).
3. Must be primarily dependent upon the employee.
4. Must be continuously disabled and covered thereafter.
5. Must be considered disabled by the Social Security Administration.

If you believe a covered dependent meets the disability criteria above you may obtain a determination of disability from the Social Security Administration. This information must be submitted to the Plan Administrator within thirty (30) days prior to the covered dependent reaching the age of twenty-six (26). You may be required to submit additional information necessary for completion of the eligibility determination.

If such eligibility is approved, you may be further required (usually not more frequently than once a year) to furnish satisfactory evidence to substantiate the continued eligibility of the covered dependent under the Plan.

**Persons Excluded as Non-Dependents:** The term “dependent” excludes:

1. Any individuals living in the covered employee’s home who do not satisfy the eligibility requirements for dependents as defined by the Plan.
2. The legally separated or divorced former spouse of the employee.
3. Any person who is on active duty in any military service of any country.
4. Any person who is covered under the Plan as an employee.

If a person covered under this Plan changes his or her status from employee to dependent or dependent to employee, and the person is covered continuously under this Plan before, during, and after the change in status, credit will be given for deductibles and all amounts applied to benefit maximums.

**Enrollment**

An eligible employee must enroll for coverage by filling out and signing an enrollment application. The covered employee is also required to enroll for dependent coverage, if dependent coverage is desired.

Under the Plan, members are classified as “timely,” “late” or “special” enrollees depending on when the completed enrollment form is received by the Plan Administrator.

**Timely Enrollment**

Enrollment is “timely” if the completed enrollment form is received by the Plan Administrator no later than thirty (30) days after the person first becomes eligible for coverage, either initially or under a special enrollment period. If the enrollment form is not submitted within this deadline, the person will be a “late enrollee” and will have to wait until the next annual open enrollment period to enroll, unless that person experiences an event permitting mid-year enrollment (See Mid-Year Enrollment Changes).

**Open Enrollment**

The Plan includes an annual Open Enrollment period. Eligible employees failing to enroll when initially eligible can enroll as “late enrollees” during Open Enrollment without having to satisfy the special enrollment requirements. In addition, members may elect to make changes in their benefit selections during the Open Enrollment period. Changes in enrollment elections will become effective as of the first day of the plan year following the Open Enrollment period. Enrollment elections will remain in effect for the entire plan year and cannot be changed unless the employee experiences certain events that permit mid-year changes (See Mid-Year Enrollment Changes).

**Late Enrollment**

An enrollment is “late” if it is not “timely” that is, if the enrollment is not completed within thirty (30) days after the person first becomes eligible to enroll or during a special enrollment period. Generally, late enrollees may enroll in the Plan only during Open Enrollment (See Open Enrollment above).

**Special Enrollment**

If an employee or the employee’s dependents are eligible but not already enrolled in the Plan, the employee may request “special enrollment” in the Plan upon either (1) the loss of other health plan coverage or (2) the addition of a new dependent as provided below:

1. **Loss of Other Health Plan Coverage:** An employee or dependent who is eligible, but not enrolled in this Plan, may enroll if all of the following conditions are met:
	1. The employee or dependent was covered under another group health plan or had health insurance coverage at the time the individual first became eligible for coverage under this Plan.
	2. The employee stated in writing at the time Plan coverage was initially offered that the other health coverage was the reason for declining enrollment in this Plan, or the employee provided sufficient documentation of coverage under another plan at the time the initial decision to decline coverage was made.
	3. The other coverage of the employee or dependent ended because:
		1. The other coverage was COBRA continuation coverage that was exhausted. COBRA continuation coverage is considered exhausted when it ceases for any reason other than the person's failure to pay premiums on a timely basis or for improper or illegal acts (such as making a fraudulent claim or an intentional misrepresentation).
		2. The other coverage was not COBRA continuation and was terminated due either to loss of eligibility for the coverage (due to legal separation, divorce, death, termination of employment, or reduction in number of hours of employment) or because employer contributions for the other coverage were terminated. An individual will not have special enrollment rights if the other coverage ended due to the individual's failure to pay premiums on a timely basis or for cause (such as making fraudulent claims or intentional misrepresentations).
		3. The employee or dependent is in a class of coverage that is no longer eligible under the terms of the other Plan.
	4. The employee submits a request for special enrollment in writing to the Plan Administrator no later than thirty (30) days after the date the other coverage terminates. Coverage will be effective no later than the first day of the month following the date the special enrollment request is received.

The above list is not an all-inclusive list of situations when an employee or dependent loses eligibility. For situations other than those listed above, see the Employer.

1. **Newly Acquired Dependents:** An employee's newly-acquired dependents may enroll in this Plan if:
	1. The employee is a participant under this Plan or, if not a participant at the time, the employee has met the probationary period applicable to becoming a participant and is eligible to be enrolled under this Plan; and
	2. The person becomes a dependent of the employee through marriage, birth, adoption, or placement for adoption.

If the employee is not yet a participant, the employee must enroll during the Special Enrollment Period in order for the newly acquired dependent to be eligible for coverage. In the case of birth or adoption of a child, the spouse of the covered employee may be enrolled as a dependent of the covered employee if the spouse is eligible for coverage.

The Special Enrollment Period is a period of not more than thirty (30) days that begins on the date of the marriage, birth, adoption, or placement for adoption.

The coverage of the employee or dependent enrolled during the Special Enrollment Period will be effective:

1. In the case of marriage, not later than the first day of the first month following the date that the completed request for enrollment is received by the Plan Administrator.
2. In the case of a dependent’s birth, as of the date of birth.
3. In the case of a dependent’s adoption or placement for adoption, the date of the adoption or placement for adoption.

The “enrollment date” for anyone who enrolls under a Special Enrollment Period is the first date of coverage.

**Mid-Year Enrollment Changes**

Once enrollment elections are made, either during the initial or Special Enrollment periods or during an annual Open Enrollment period, those elections may not be changed and will remain in effect for the entire plan year. However, there are some important exceptions:

1. **Change in Status:** Employees may revoke or modify their enrollment elections mid-year only if they experience a Change in Status that affects their eligibility or the eligibility of their dependents under this Plan. A “Change in Status” is one of the following events:
	1. **Change in legal marital status**, including marriage, death of spouse, divorce, legal separation or annulment.
	2. **Change in number of dependents**, including birth, adoption, placement for adoption, and death of a spouse or other dependent.
	3. **A dependent satisfying or ceasing to satisfy the requirements for coverage.**
	4. **Change in employment status** of the employee, the employee's spouse or other dependent, including termination or commencement of employment, taking or returning from an unpaid leave of absence, change in work site, change in full-time or part-time status, change in hourly or salaried status, change in dependent's eligibility for other employer-based coverage.
	5. **Change in residence** by the employee, the spouse or dependent.
	6. **Reduction in hours of service** during stability period from full-time to part-time status.

An election change will be approved only if it is consistent with the Change in Status. An election change is “consistent with” a Change in Status if the change is both the result of and corresponds with the Change in Status. For example, if a child ceases to be eligible for coverage because of age, it would be consistent with the Change in Status to drop coverage for the child. However, it would not be consistent with the Change in Status to drop coverage for the employee. As another example, if a spouse is covered under the medical plan of the spouse’s employer, and the spouse loses coverage under that plan because of a change from full-time to part-time employment, it would be consistent with the Change in Status for the employee to elect to add the spouse under this Plan.

1. **Change in Cost or Coverage**

If the cost of benefits increases or decreases during a benefit period, the Plan Sponsor may automatically change employee premium contributions. When the change in cost is significant, employees will be given the opportunity to either increase their contributions or elect a less costly option (if available).

If there is a significant overall reduction in the Plan’s coverage, employees may elect another benefit option (if available). If a new benefit option is added under the Plan, employees will have the right to change their election to the new benefit option.

1. **Qualified Medical Child Support Order (QMCSO)**

A QMCSO is a judgment, decree or order resulting from a divorce, legal separation, annulment or change in custody that requires health coverage for an employee’s child. An employee may change his or her Plan enrollment elections if the employee becomes subject to a QMCSO that requires the employee to provide (or cancel) health care coverage for a child.

1. **Entitlement to Medicare**

An employee may change his or her elections for Plan coverage if the employee or any dependent becomes entitled to or loses Medicare coverage.

1. **Entitlement to Medicaid or Children’s Health Insurance Coverage Reauthorization Act (CHIPRA)**

**Eligible employees enrolled in Medicaid or CHIPRA may enroll in the Plan by submitting** a completed Enrollment Change form to the Plan Administrator within 60 days of loss of coverage.

An employee may change his or her elections for Plan coverage if the employee or any dependent becomes entitled to or loses Medicaid or **CHIPRA.**

**Rescission:** Fraud and intentional misrepresentation of a material fact by employees or covered persons are prohibited. The Plan shall have the right to rescind coverage if a covered person performs an act, practice or omission that constitutes fraud or makes an intentional misrepresentation of a material fact relating to health care or coverage. Thirty (30) days advance written notice will be provided to the person for whom coverage is being rescinded. An employee has the right to appeal a rescission of coverage (See Appeals section). A rescission is a cancellation or discontinuance of coverage that has a retroactive effect.

**Employee Coverage Termination:** Employee coverage will terminate on the earliest of the following dates:

1. The date following the last day for which premiums were paid when the covered employee terminates employment.
2. The date on which the covered employee ceases to be in a class eligible for coverage.
3. The date on which this Plan is terminated, or in case of any benefit under this Plan, the date of termination of the specific benefit.
4. The date the covered employee dies.
5. The date the covered employee enters the military service of any country or international organization on a full-time active duty basis other than scheduled drills or other training not exceeding one (1) month in any calendar year.
6. The date the covered employee fails to make any required contribution for coverage.
7. The date on which a cancellation or discontinuance of coverage due to rescission is effective retroactively, as provided above.

A covered employee may be eligible for COBRA continuation coverage. For a complete explanation of COBRA availability, see the section entitled COBRA Continuation Coverage.

**Coverage Continuation During Periods of Employer-Certified Disability, Leave of Absence, or Layoff:** A person may remain eligible for a limited time if active, full-time work ceases due to disability, leave of absence, or layoff. This continuation will end as follows:

1. **For Employer-Certified Disability leave only.** The end of the **three (3)** calendar month period immediately following the month in which the person last worked as an active employee.
2. **For Leave of Absence or Layoff only.** The end of the **three (3)** calendar month period immediately following the month in which the person last worked as an active employee.
3. **For Personal Leave.** Personal leaves may be granted for up to forty-five (45) days. Leave may represent a combination of paid and unpaid leave, with the unpaid portion not to exceed thirty (30) days. Employee benefits will remain in force until the end of the paid portion of the personal leave. When the unpaid leave extends beyond 10 working days, **the employee is responsible for the full cost of his/her benefits** during the leave if coverage is to continue.

While continued, coverage will remain the same as the coverage in effect on the employee’s last day worked as an active employee. However, if benefits are modified or reduced for others in the employee’s class, benefits will also be modified or reduced for the continued person.

**Coverage Continuation During Family and Medical Leave:** Regardless of the leave policies described elsewhere in this Plan, this Plan will at all times comply with the Family and Medical Leave Act of 1993 and applicable regulations issued by the Department of Labor.

An eligible employee who is the spouse, son, daughter, parent or “next to kin” (defined as the nearest blood relative) of a injured US Armed Services member who is recovering from a serious illness or injury sustained in the line of duty on active duty is entitled to a total of 26 work weeks of leave during a 12-month period to care for the service member. (In compliance with the Family and Medical Leave Act of 1993 and applicable regulations issued by the Department of Labor). During any leave taken under the Family and Medical Leave Act (FMLA), the employer will maintain coverage under this Plan under the same terms and conditions as coverage which would have been provided if the covered employee had been continuously employed during the entire leave period. The employee will continue paying any required contributions during the leave.

If Plan coverage is discontinued during the FMLA leave (either upon the employee’s election or for failure to pay required contributions during the leave), coverage will be reinstated for the employee and his or her covered dependents if the employee returns to work in accordance with the terms of the FMLA leave. Coverage will be reinstated only if the person had coverage under this Plan when the FMLA leave started and will be reinstated to the same extent as the coverage that was in force when coverage was discontinued. For example, waiting periods will not be imposed unless they were in effect for the employee and/or the employee’s dependents when Plan coverage was discontinued for the period of leave.

**Rehiring a Terminated Employee:** Any employee who terminates with less than forty-eight (48) months of service and is subsequently rehired will be treated as a new hire. If an employee terminates after forty-eight (48) months or more of service and is rehired after a break in service on one year or less, the employee will be eligible for immediate enrollment in the Plan. If the break in service exceeds one year the employee will be treated as a new hire for eligibility and enrollment purposes.

**Employees on Military Leave:** Employees entering into or returning from military service will have the rights mandated by the Uniformed Services Employment and Reemployment Rights Act (“USERRA”). These rights include up to twenty-four (24) months of extended health care coverage upon payment of the entire cost of coverage plus a reasonable administration fee, and immediate coverage upon return from military service. These rights apply only to employees and their dependents covered under the Plan before active military service begins.

Plan exclusions and waiting periods may be imposed for any sickness or injury determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, military service.

**Termination of Dependent Coverage:** A dependent’s coverage will terminate on the earliest of these dates:

1. The date on which the covered dependent ceases to be an eligible dependent.
2. The date the covered employee’s coverage under this Plan terminates.
3. The date on which the covered employee ceases to be in a class eligible for dependent coverage
4. The date this Plan is terminated, in the case of any covered dependent's benefit under this Plan, the date of termination of such benefit
5. The date the covered dependent enters the military service of any country or international organization on a full-time active duty basis other than scheduled drills or other training not exceeding one month in any calendar year
6. The date the covered employee fails to make any required contribution for dependent coverage. A covered dependent may be eligible for COBRA continuation coverage. For a complete explanation of COBRA availability, see the section entitled COBRA Continuation Coverage.

### PROCEDURE

**How to Make Mid-Year Enrollment Changes**

If an employee experiences an event that allows the employee to make a mid-year enrollment change, the employee must submit a completed Enrollment Change Form to the Plan Administrator no later than thirty (30) days after the event occurs. If the employee does not request the coverage change within the specified time limit, the employee will lose the right to make a change allowed by that event.

**How to Make Mid-Year Enrollment Changes for Medicaid or CHIPRA**

If an employee experiences an event that allows the employee to make a mid-year enrollment change, the employee must submit a completed Enrollment Change Form to the Plan Administrator no later than sixty (60) days after the event occurs. If the employee does not request the coverage change within the specified time limit, the employee will lose the right to make a change allowed by that event.

**Effective Date**

If approved, the employee’s enrollment change(s) will take effect:

1. On the date of the event, in the case of a birth, adoption or placement for adoption.
2. No later than the first day of the month following the date the Plan Administrator receives the employee's completed Enrollment Change Form, in the case of all other enrollment changes.