OPEN ENROLLMENT

Visalia UNIFIED SCHOOL DISTRICT

Human Resources/Employee Benefits

TO: Classified Employee/Classified Management/District Paid Retiree-OPEN ENROLLMENT

FROM: Benefits Technician

RE: Spousal Overlay Program Requirement

The District and the California School Employee Association (CSEA) reached an agreement with regards to the health benefits implementing the new Spousal Overlay Program which applies to the classified employees/district paid retirees with spouses/registered domestic partners who work thirty (30) hours or more per week, are not employed by Visalia Unified, and are eligible for their employer's group health plan.

Under this program, if your spouse/registered domestic partner work 30 hours or more for an employer outside of VUSD and is eligible for medical benefits through their employer's group health plan now or at a future date, then *her/she must enroll in the employer's plan at the earliest date eligible in order to be covered or continue to be covered as a dependent under the Visalia Unified School District health plan*.

As part of the health benefit enrollment process, the attached yellow Spousal Overlay Requirement Form must be completed by the new hired employee and the Verification of Employment and Employer Group Health Plan Eligibility Form must be completed by the spouse's employer, if applicable.

For those affected by the requirement of this program, the spouse/registered domestic partner must enroll, if eligible, through their own employer, at the earliest date eligible, *regardless of the cost to do so.* **Once enrollment into their own employer's group health plan has been established, Visalia Unified's plan will be a secondary coverage to the spouse's group employer plan.** An individual health plan cannot be substituted in place of an employer group health plan.

If the spouse is employed and is not a Visalia Unified employee; the spouse is not eligible for their employer group plan; the spouse is currently eligible or will be eligible at a future date; or is currently covered by their employer's group plan the following will apply:

- **Proof of the spouse's *current employer health plan coverage*** must be presented during the enrollment process with Visalia Unified, prior to Visalia health benefits start date.

- Completion of the **Spouse/Registered Domestic Partner's Employer Group Health Plan Eligibility Verification Form**. The spouse's employer must complete the Eligibility Verification Form to verify current or upcoming group plan eligibility with their company by the deadline date indicated. The form must be returned completed to Visalia Unified for your spouse to be enrolled for benefits with Visalia Unified.

If any one of these Spousal Overlay requirements is not met by your enrollment start date or the given deadline, your spouse will not be enrolled into your plan. The health insurance eligibility guideline indicates if a spouse is not enrolled within 31 days of the initial eligibility date (hire date), the next opportunity to enroll your spouse would not be until the next Open Enrollment period (September 1 – 30) of each given year. The coverage start date for the Open Enrollment period is October 1 of the same year.

OPEN ENROLLMENT

Visalia Unified School District

Spousal Overlay Program Requirements for Classified Employees/Retirees with VUSD Health Benefits

You must complete and return this form to Risk Management in order for your spouse/registered domestic partner to have Visalia Unified health insurance coverage (No benefit payments will be made until this form is signed and returned)

Employee Name (Print): _____

☐ **I do not have a Spouse/Registered Domestic Partner**

☐ **My Spouse/Registered Domestic Partner is** (print full legal name): _____

Please mark the appropriate information about your Spouse/Registered Domestic Partner:

☐ **Is exempt from Spousal Overlay requirements: ____ Does not work /retired OR ____ Is employed with VUSD, OR _____ Is employed, but works less than 30 hours per week (Spouse's Employer Verification Form Required)**

☐ **Is employed with** (Employer Name) _____ **and <u>is currently covered by employer's group plan</u>:** (Copy of Insurance ID card and **Spouse's Employer Verification Form Required**)

☐ **Is employed and works 30 hours or more with** (Employer Name) _____ **and <u>is eligible</u>, (but not currently enrolled) for employer's group plan:** (Name of Plan) *_____.
To be eligible on VUSD health plan, enrollment is required as soon as available*. **(Insurance ID and Spouse's Employer Verification Form Required**)

☐ **Employed and works 30 hours or more with** (Employer Name) _____ **but <u>is not eligible</u> for health insurance (Spouse's Employer Verification Form is Required)**

Effective October 1, 2008, the Spousal Overlay Program shall apply to employee/retiree's spouses/domestic partners who are not employed by VUSD, work thirty (30) hours or more per week, and are eligible for their employer's group health plan.

- The spouse/registered domestic partner of a VUSD employee or retiree who works 30 hours or more for an employer outside of VUSD and is eligible for medical benefits through their employer's group health plan **<u>must be enrolled in their employer's plan</u>** in order to be covered as a dependent under the Visalia Unified School District health plan. An individual health plan cannot be substituted in place of this coverage.
- Any change in the marital status or spouse/registered domestic partner's employment, or any other change to employee or dependents eligibility status must be reported immediately to the district on a district provided form.
- The spouse/registered domestic partner of an employee/retiree covered by the VUSD health plan, so long as that employee has not experienced a "qualifying event" as that term is defined in 29 U.S.C. 1163 (COBRA), who is eligible for medical benefits in the spouse's or domestic partner's group health plan, must enroll in the spouse's/registered domestic partner's group health plan <u>when becoming eligible.</u>
- **<u>If your spouse/registered domestic partner is not currently eligible for medical benefits where he or she works, but becomes eligible at a later date, he or she must enroll in the employer Plan when first eligible and notify the district office</u>**. The SISC PPO plan then changes from Primary Carrier to Secondary Carrier.
- If the employee/retiree is found to be in violation of the spousal overlay requirements. SISC will notify VUSD and VUSD will submit paperwork to SISC to terminate the spouse/domestic partner's coverage retroactively. SISC will then recover paid claims.

I acknowledge that I have read and understand the aforementioned VUSD classified spouse/registered domestic partner eligibility requirement for coverage under the VUSD health insurance. Failure to comply will render my spouse or domestic partner's coverage under VUSD classified health suspended until such a time as this requirement has been met. Falsifying information will be considered fraud.

_____ _____

Signature **Date**

TO: Employee/Retiree with District Paid Health Benefits

FROM: HRD Benefits

RE: **Verification of Employment and Employer Group Health Plan Eligibility For the VUSD Spousal Overlay Program Requirements**

As a part of the Spousal Overlay Program requirement, your spouse/registered domestic partner's employer must complete the attached "Verification of Employment and Employer Group Health Plan Eligibility" form in order for your spouse/registered domestic partner to be enrolled on your health plan with Visalia Unified.

Please have your spouse/registered domestic partner to ask his/her employer to complete and return the attached verification form to Human Resources Employee Benefits.

If you have any questions or need assistance please contact Human Resources at 730-7538.

Visalia Unified School District

Verification of Employment and Employer Group Health Plan Eligibility For the VUSD Spousal Overlay Program Requirements

To: Spouse's Employer

This form is requesting employment verification regarding _____,
(Spouse's Name)

who is the spouse/ registered domestic partner of _____?
(Visalia Unified's Employee Name)

a Visalia Unified School District management employee/retiree. The Visalia Unified School District has implemented a spousal overlay program as a part of the management employees' health benefit plan. This new program has requirements which may affect employed spouses/registered domestic partners of VUSD classified and management employees/retiree. The spousal overlay program requires the following:

> The spouse/registered domestic partner of a VUSD management or classified employee or retiree who **works 30 hours or more for an employer outside of VUSD** and is eligible for medical benefits through their employer's group health plan **must be enrolled in their employer's plan** in order to be covered as a dependent under the Visalia Unified School District health plan. An individual health plan cannot be substituted in place of this coverage.

Please confirm the following for your employee:

☐ This individual is normally scheduled and work less than 30 hours per week.

☐ This individual is normally scheduled and works 30 hours or more per week; however, no employer group benefits are available through our company.

☐ This individual is normally scheduled and works 30 hours or more per week.

- Is any group health insurance coverage offered for this individual? ___ Yes ___ No
- If coverage is offered but not currently enrolled, would this individual be eligible to participate in the future? If so, what would be the soonest date available: _____
- Is this individual currently enrolled in your employer group health plan? ___ Yes ___ No
  (Please provide Name of Plan and Group Number) _____

_____	_____	_____
Name (Printed)	Signature	Date
_____	_____	_____
Title	Company	Phone No.

Fax: Visalia Unified School District – HRD Benefits at 559-735-8099
Mail: VUSD – HRD Benefits, 5000 West Cypress Avenue, Visalia CA 93277

OPEN ENROLLMENT

SISC III
SELF-INSURED SCHOOLS OF CALIFORNIA
Schools Helping Schools

SISC III MEMBERSHIP CHANGE FORM

PRINT CLEARLY IN BLACK OR BLUE INK

SUBSCRIBER CHANGES

NAME OF SUBSCRIBER LAST NAME (PRINT)	FIRST NAME (PRINT)	SOCIAL SECURITY NO.

DISTRICT USE ONLY (Required)

DISTRICT NAME (Do not abbreviate):

VISALIA UNIFIED

REQUESTED EFFECTIVE DATE: / /

MEDICAL GROUP NO.:

DISTRICT APPROVED

INITIALS: ________

75% OPTION – PROVIDE SPOUSE SOCIAL SECURITY NO.

NAME CHANGE

☐ Subscriber name only ☐ Spouse ☐ Domestic Partner ☐ Child

	LAST NAME (PRINT)	FIRST NAME (PRINT)
OLD NAME(S):		
NEW NAME(S):		

SUBSCRIBER OLD ADDRESS	SUBSCRIBER NEW ADDRESS
Old Address	New Address
City/State/Zip	City/State/Zip
Old Phone No. ( )	New Phone No. ( )

SOCIAL SECURITY NO. AND DATE OF BIRTH CHANGES

☐ CHANGE SOCIAL SECURITY NO. FOR: ____________________ FROM: ____________ TO: ____________

☐ CHANGE DATE OF BIRTH FOR: ____________________ FROM: ____________ TO: ____________

DEPENDENT CHANGES *Proof of eligibility required (i.e. birth/marriage/domestic partner certificate).*

District Use ☐ ADD ☐ DELETE	☐ SPOUSE ☐ DOMESTIC PARTNER ☐ M ☐ F	LAST NAME (PRINT)	FIRST NAME (PRINT)	MI	SOCIAL SECURITY NO.
		REASON FOR CHANGE:			

☐ MEDICAL ☐ DENTAL ☐ VISION	DATE OF BIRTH / /	AGE	ELIGIBLE FOR OTHER HEALTH PLAN? ☐ YES ☐ NO	ENROLLED IN OTHER HEALTH PLAN? ☐ YES ☐ NO	IPA (HMO ONLY – REQUIRED)	PCP (HMO ONLY – REQUIRED)	IS THIS YOUR CURRENT PROVIDER? ☐YES ☐NO

☐ ADD ☐ DELETE	☐ SON ☐ DAUGHTER	LAST NAME (PRINT)	FIRST NAME (PRINT)	MI	SOCIAL SECURITY NO.
		REASON FOR CHANGE:			

☐ MEDICAL ☐ DENTAL ☐ VISION	DATE OF BIRTH / /	AGE	ELIGIBLE FOR OTHER HEALTH PLAN? ☐ YES ☐ NO	ENROLLED IN OTHER HEALTH PLAN? ☐ YES ☐ NO	IPA (HMO ONLY – REQUIRED)	PCP (HMO ONLY – REQUIRED)	IS THIS YOUR CURRENT PROVIDER? ☐YES ☐NO

☐ ADD ☐ DELETE	☐ SON ☐ DAUGHTER	LAST NAME (PRINT)	FIRST NAME (PRINT)	MI	SOCIAL SECURITY NO.
		REASON FOR CHANGE:			

☐ MEDICAL ☐ DENTAL ☐ VISION	DATE OF BIRTH / /	AGE	ELIGIBLE FOR OTHER HEALTH PLAN? ☐ YES ☐ NO	ENROLLED IN OTHER HEALTH PLAN? ☐ YES ☐ NO	IPA (HMO ONLY – REQUIRED)	PCP (HMO ONLY – REQUIRED)	IS THIS YOUR CURRENT PROVIDER? ☐YES ☐NO

☐ ADD ☐ DELETE	☐ SON ☐ DAUGHTER	LAST NAME (PRINT)	FIRST NAME (PRINT)	MI	SOCIAL SECURITY NO.
		REASON FOR CHANGE:			

☐ MEDICAL ☐ DENTAL ☐ VISION	DATE OF BIRTH / /	AGE	ELIGIBLE FOR OTHER HEALTH PLAN? ☐ YES ☐ NO	ENROLLED IN OTHER HEALTH PLAN? ☐ YES ☐ NO	IPA (HMO ONLY – REQUIRED)	PCP (HMO ONLY – REQUIRED)	IS THIS YOUR CURRENT PROVIDER? ☐YES ☐NO

SUBSCRIBER SIGNATURE	DATE

MUST BE SUBMITTED WITHIN 30 DAYS OF QUALIFYING EVENT