

[Home](#)[Back](#)[Forward](#)

COV Group Voluntary Long-Term Care Insurance

The Commonwealth of Virginia (COV) Voluntary Group Long-Term Care Insurance Program provides a monthly benefit allowance to help cover the cost of long-term care services, such as nursing home care or at-home care to assist with bathing, eating or other activities of daily living. Coverage is participant-paid. VRS has contracted with Genworth Life Insurance Company as the insurer for the program.

Eligibility

The following employees are eligible for the COV Voluntary Group Long-Term Care Insurance Program:

- State employees who work at least 20 hours a week; employees do not have to be VRS members;
- Employees and faculty (including adjunct) of a Virginia public institution of higher education who work at least 20 hours a week; employees do not have to be VRS members;
- School division employees or political subdivision employees who work at least 20 hours a week, provided the employer has elected to participate in the program. Employees do not have to be VRS members;
- Deferred VRS members under age 75 who are vested with at least 5 years or more of VRS-covered service;
- Retirees under age 75 receiving a VRS-administered benefit;
- Retirees of a Virginia public college or university under age 75.

If the member is a deferred VRS member or retiree, the employer is not required to have elected the program. The member is subject to full medical underwriting regardless of the member's age at the time of application.

Family members may also apply for coverage if they are between the ages of 18 and 75 and undergo full medical underwriting. Eligible family members include:

- Spouses and surviving spouses;
- Adult children;
- Parents, parents-in-law and step-parents;
- Siblings;
- Grandparents, grandparents-in-law, step-grandparents and step-grandparents-in-law.

[Eligibility](#)[Enrollment](#)[Premiums](#)[Program Options](#)

- Options Prior to January 1, 2017
- Options After January 1, 2017

[Benefit Increase Options](#)[Benefits](#)[Pre-Existing Conditions Limitation](#)[Exclusions](#)[Coordinated Coverage](#)[Resources](#)

[Home](#)[Back](#)[Forward](#)

Enrollment

To enroll in the program, applicants should visit the Genworth Life website (www.genworth.com/COV) and fill out an online application. Applicants will receive a confirmation email that their information has been received.

Medical underwriting (proof of good health) is reduced if the participant is age 65 and under and applies within 60 days of employment. Full medical underwriting will be required after 60 days or if the participant is over age 65. Full medical underwriting is required for any family members who apply, or if the participant is a VRS deferred member or retiree. Medical underwriting may include a health questionnaire, a request for medical records or in some instances, a 20- to 30-minute telephone interview.

Premiums

Premiums are paid directly to Genworth by the employee and may be automatically deducted from a checking or savings account on a monthly, quarterly, semi-annual or annual basis. Premium rates are guaranteed through March 1, 2020 and until then will increase only if the employee makes a change in coverage.

Program Options

During enrollment, an employee chooses three elements: the monthly benefit, the total coverage amount and the benefit increase option. The amount of each varies, depending on the employee's date of enrollment. Employees enrolled before January 1, 2017 are entitled to the program options outlined below. Employees enrolled after January 1, 2017 are entitled to a different set of program options, outlined later in the section.

Options Prior to January 1, 2017

The monthly benefit is the maximum amount the plan covers for qualifying long-term care expenses each month. The available choices are:

- \$3,000;
- \$4,500;
- \$7,500.

[Eligibility](#)[Enrollment](#)[Premiums](#)[Program Options](#)

- Options Prior to January 1, 2017
- Options After January 1, 2017

[Benefit Increase Options](#)[Benefits](#)[Pre-Existing Conditions Limitation](#)[Exclusions](#)[Coordinated Coverage](#)[Resources](#)



[Home](#)



[Back](#)



[Forward](#)

Once the monthly benefit amount is selected, the employee chooses the maximum lifetime benefit amount, which is the total coverage available under the plan. This pool of money pays for the long-term care expenses over the lifetime of the plan. The three choices are:

- Two times the monthly benefit amount multiplied by 12;
- Three times the monthly benefit amount multiplied by 12;
- Five times the monthly benefit amount multiplied by 12.

The table below shows the monthly benefit choices and the corresponding total coverage amounts (maximum lifetime benefit options). For example, if the selected monthly benefit amount is \$3,000, the employee can choose total coverage (maximum lifetime benefit amount) of \$72,000, \$108,000 or \$180,000.

Monthly Benefit	Total Coverage (Maximum Lifetime Benefit)		
\$3,000	\$72,000	\$108,000	\$180,000
\$4,500	\$108,000	\$162,000	\$270,000
\$7,500	\$180,000	\$270,000	\$450,000

For information on benefits and benefits increase options for this program, see the Benefits and Benefits Increase Options section of this chapter. Participants may also refer to their certificate of insurance for additional information.

Options After January 1, 2017

The monthly benefit is the maximum amount the plan covers for qualifying long-term care expenses each month. The available choices are:

- \$3,000;
- \$4,500;
- \$6,000.

Once the monthly benefit amount is selected, the employee chooses the maximum lifetime benefit amount, which is the total coverage available under the plan. This pool of money pays for the long-term care expenses over the lifetime of the plan. The three choices are:

- Two times the monthly benefit amount multiplied by 12;
- Three times the monthly benefit amount multiplied by 12;
- Four times the monthly benefit amount multiplied by 12.

[Eligibility](#)

[Enrollment](#)

[Premiums](#)

[Program Options](#)

- Options Prior to January 1, 2017
- Options After January 1, 2017

[Benefit Increase Options](#)

[Benefits](#)

[Pre-Existing Conditions Limitation](#)

[Exclusions](#)

[Coordinated Coverage](#)

[Resources](#)



[Home](#)



[Back](#)



[Forward](#)

The table below shows the monthly benefit choices and the corresponding total coverage amounts (maximum lifetime benefit options). For example, if the selected monthly benefit amount is \$3,000, the employee can choose total coverage (maximum lifetime benefit amount) of \$72,000, \$108,000 or \$144,000.

Monthly Benefit	Total Coverage (Maximum Lifetime Benefit)		
\$3,000	\$72,000	\$108,000	\$144,000
\$4,500	\$108,000	\$162,000	\$216,000
\$6,000	\$144,000	\$216,000	\$288,000

Benefit Increase Options

In addition to choosing a monthly benefit and maximum lifetime benefit option, an employee also chooses one of three benefit increase options. Benefit increase options allow coverage to increase over time to help with the rising cost of care.

The benefit increase options are:

- Future Purchase Option;
- 3% Compound for Life;
- 5% Compound for Life.

The Future Purchase Option allows an employee to purchase more coverage every three years. If the offer is accepted, the monthly benefit amount and total coverage amount (less any claims paid) will increase by 5%, compounded annually for the three-year period (an approximate increase of 15.76%). This feature is automatically included in the plan the employee selects. Evidence of good health is not required at the time of the increase; however, increases will not be available or effective and may be revoked or rescinded if the employee is chronically ill or eligible for claim on the date the offer is accepted.

The Future Purchase Option allows for lower premiums today than what is provided with other benefit increase choices. The employee chooses when to increase coverage based on individual needs at the time of the offer. However, the premiums are based on the employee’s age at the time the offer is accepted and the amount of the increase. If the employee declines the offer two consecutive times, there will be no subsequent opportunities to increase coverage.

[Eligibility](#)

[Enrollment](#)

[Premiums](#)

[Program Options](#)

- Options Prior to January 1, 2017
- Options After January 1, 2017

[Benefit Increase Options](#)

[Benefits](#)

[Pre-Existing Conditions Limitation](#)

[Exclusions](#)

[Coordinated Coverage](#)

[Resources](#)



[Home](#)



[Back](#)



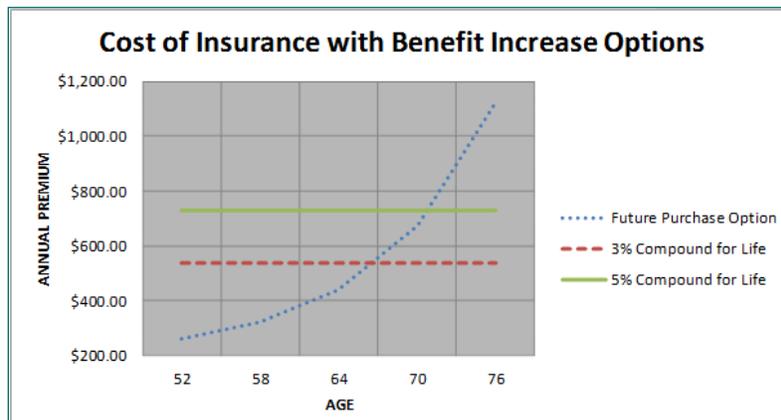
[Forward](#)

Under the 3% Compound for Life option, the monthly benefit and total coverage amount (less any claims paid) automatically increase by 3% compounded every year. This option has a higher initial premium but the premium does not increase each time the benefits increase. Evidence of good health is not required at the time of the increase. Election of the 3% Compound for Life option qualifies the participant for the Partnership Plan, which allows the participant to receive plan benefits and still possibly qualify for Medicaid.

The 5% Compound for Life option is the most comprehensive inflation protection available with the plan. The monthly benefit and total coverage amount (less any claims paid) automatically increases by 5% compounded every year. This option has a higher initial premium but the premium does not increase each time the benefits increase. Evidence of good health is not required at the time of the increase. Election of the 5% Compound for Life option qualifies the participant for the Partnership Plan, which allows the participant to receive plan benefits and still possibly qualify for Medicaid.



The chart below compares the annual premium paid by a 52-year-old for policies with Future Purchase Option; 3% Compound for Life and 5% Compound For Life. It assumes an initial choice of a monthly maximum of \$3,000 per month and a total coverage (lifetime maximum) amount of \$108,000. The chart assumes that under the Future Purchase Option, the employee elects the increase offer every sixth year.



[Eligibility](#)

[Enrollment](#)

[Premiums](#)

[Program Options](#)

- Options Prior to January 1, 2017
- Options After January 1, 2017

[Benefit Increase Options](#)

[Benefits](#)

[Pre-Existing Conditions Limitation](#)

[Exclusions](#)

[Coordinated Coverage](#)

[Resources](#)

Benefits

An employee may qualify for benefits if the employee is in need of assistance with two activities of daily living and the assistance is expected to be needed for at least 90 days.



[Home](#)



[Back](#)



[Forward](#)

The employee may also qualify for benefits if the employee has a severe cognitive impairment and requires supervision.

After a doctor, nurse, social worker or other appropriately licensed treating healthcare professional certifies the employee’s inability to perform two activities of daily living or that the employee has a severe cognitive impairment, benefits begin after a 90-day long-term-care waiting period. The 90-day waiting period begins on the first day of receiving covered long-term care services. The employee is only required to satisfy one 90-day waiting period per lifetime.

Coverage under the COV Group Long-Term Care Insurance Program includes the following:

Coverage Type	Description
Care Coordination Services	These services are intended to help identify care needs and community resources available to deliver care. The services are furnished by a team of covered care coordinators provided by Genworth. The cost of the services are at Genworth’s expense and do not count against any payment maximum.
Nursing Facility Benefit	Nursing facility means a facility that is engaged primarily in providing continual (24 hours a day, every day) nursing care to all of its residents or inpatients in accordance with the authority granted by a license issued by the federal government or the state in which it’s located. The maximum payable each month is the lesser of the monthly benefit amount elected under the plan or the cost incurred. This benefit is subject to the 90-day waiting period and the lifetime maximum.
Assisted Living Facility Benefit	Assisted living facility means a facility (including one for people with Alzheimer’s) that is engaged primarily in providing maintenance or personal care services to its residents and that meets all applicable licensing requirements. The amount payable each month under the assisted living facility benefit is the lesser of the monthly benefit amount elected under the plan or the cost incurred. This benefit is subject to the 90-day waiting period and the lifetime maximum.
Bed Reservation Benefit	This benefit will pay up to the maximum monthly benefit amount for the cost of reserving accommodations in a nursing facility or assisted living facility if the participant is temporarily absent from the facility for any reason. The amount payable is up to the lesser of the monthly benefit amount elected under the plan or the cost incurred. This benefit is payable for a maximum of 60 days per calendar year and is subject to the 90-day waiting period and the policy lifetime maximum.
Home and Community Care Benefits	Home and community care benefits include adult day care, nurse and therapist services, home health or personal care service and incidental homemaker and chore care. The amount payable under the plan is the lesser of 50% of the monthly benefit amount elected under the plan or the cost incurred. This benefit is subject to the 90-day waiting period and the policy lifetime maximum.

[Eligibility](#)

[Enrollment](#)

[Premiums](#)

[Program Options](#)

- Options Prior to January 1, 2017
- Options After January 1, 2017

[Benefit Increase Options](#)

[Benefits](#)

[Pre-Existing Conditions Limitation](#)

[Exclusions](#)

[Coordinated Coverage](#)

[Resources](#)



[Home](#)



[Back](#)



[Forward](#)

Informal Care Benefit	<p>Informal care services are maintenance or personal care services another person provides in the home to enable independent living at home. The benefit payable is the actual expenses incurred up to a maximum benefit payable of 1% of the monthly benefit amount elected under the plan per calendar day for no more than 30 days per year. Payment under this benefit cannot be used to satisfy the 90-day waiting period and is subject to the policy lifetime maximum.</p>
Hospice Care Benefit	<p>Hospice care means expenses incurred for care and support services in a hospice care facility, nursing facility or assisted living facility. These expenses are paid based on the lesser of the expenses incurred or the monthly benefit elected under the plan. A covered expense also means covered expenses for home health or personal care services and incidental homemaker and chore care. The lesser of 50% of the monthly benefit amount elected under the plan or the expense incurred is paid for home health or personal care services and incidental homemaker and chore care. The hospice care benefit cannot be used to satisfy the 90-day waiting period and it is subject to the policy lifetime maximum.</p>
Respite Care	<p>This benefit provides temporary short-term relief for persons who normally and primarily care for the covered individual at home on a regular and unpaid basis. Covered expenses for respite care means care in a nursing facility, care in an assisted living facility and home and community care. The benefit pays the lesser of the monthly benefit elected under the plan or the expenses incurred. Payment of this benefit is not subject to the 90-day waiting period and days of covered care under it cannot be used to satisfy the 90-day waiting period. The respite care benefit is also subject to the policy lifetime maximum.</p>
Alternate Care Benefit	<p>Services, devices or treatments not otherwise payable under the plan that Genworth has determined are cost-effective, appropriate to the employee's needs, consistent with general standards of care, provide an equal or greater quality of care than otherwise provided by the coverage, qualified long-term care services and are clearly specified in the plan of care and in a separate written mutual agreement between Genworth, the participant and if appropriate, the employee's physician. The written agreement will state how the 90-day waiting period affects payment and any time and payment maximums. The alternate care benefit is subject to the lifetime maximums.</p>

[Eligibility](#)

[Enrollment](#)

[Premiums](#)

[Program Options](#)

- Options Prior to January 1, 2017
- Options After January 1, 2017

[Benefit Increase Options](#)

[Benefits](#)

[Pre-Existing Conditions Limitation](#)

[Exclusions](#)

[Coordinated Coverage](#)

[Resources](#)

Pre-Existing Conditions Limitation

Covered expenses incurred for any loss or confinement that is a result of a pre-existing condition, when the loss or confinement occurs within six months following the initial certificate effective date, will not be covered by Genworth. Benefits will be paid for covered expenses incurred for any such loss or confinement that occurs after the six-month period, regardless of when such loss or confinement began. A pre-existing condition means a condition (illness, disease, injury or symptom) for which medical advice or treatment was recommended by, or received from, a health care professional within six months prior to the initial certificate effective date.



[Home](#)



[Back](#)



[Forward](#)

Exclusions

The plan does not cover items such as room, board, treatment, care and equipment if:

- The participant would not have been charged for them if uninsured;
- The participant receives care or services outside of the District of Columbia or the United States and its territories or possessions, except as covered by the International Coverage benefit;
- The participant’s immediate family provides care or services that are not covered by an Informal Care benefit. The care may be covered if the family member is a regular employee of the organization that is providing the services, the organization receives payment for the services, and the family member receives no compensation other than the normal compensation for employees in that job category;
- Alcoholism, addiction to drugs or narcotics, except for addiction to prescription drugs, which the participant took only as directed by a physician;
- The participant receives care in a Veteran’s Administration or other federal government facility, unless a valid charge is made.

The plan does not reimburse expenses if the need for long term care is the result of:

- War or an act of war, whether declared or undeclared;
- Attempted suicide or self-inflicted injury;
- Participation in a felony, riot or insurrection;
- Service in the armed forces or units auxiliary thereto.

State variations may apply to these exclusions and limitations. The specific language may vary or change the impact of the exclusion.

Coordinated Coverage

Benefits under this insurance coordinate with other group long term care insurance meaning that the sum of all benefits received will not exceed the actual charges.

Benefits will not duplicate benefits received under another insurance program such as:

- Medicare;
- Virginia Sickness and Disability Program (VSDP) Long-Term Care Plan;
- Virginia Local Disability Program (VLDP) Long-Term Care Plan;
- Any state or federal worker’s compensation, employer’s liability or occupational disease law;
- Any other federal, state or government health care or long-term care program or law except Medicaid.

Policy benefits from the above long-term care programs may be coordinated with the Commonwealth of Virginia Group Long-Term Care Insurance Program to obtain

[Eligibility](#)

[Enrollment](#)

[Premiums](#)

[Program Options](#)

- Options Prior to January 1, 2017
- Options After January 1, 2017

[Benefit Increase Options](#)

[Benefits](#)

[Pre-Existing Conditions Limitation](#)

[Exclusions](#)

[Coordinated Coverage](#)

[Resources](#)

additional coverage. For further information on coordinating coverage, see the VLDP chapter of the Employer Manual or the VSDP chapter of the Employer Manual.

Resources

For program materials to distribute to employees, employers may visit the Employer Hub on the VRS website (<https://employers.varetire.org/employer-hub/>). Employers may also reference the page for the COV Voluntary Group Long-Term Care Insurance Program on the VRS employer website (<https://employers.varetire.org/plans-and-benefits/benefits/long-term-care/cov-voluntary-long-term-care.html>).

For additional information, employers and members may contact Genworth Life directly:

Genworth
Group Processing Center; P.O Box 64010
St. Paul, MN 55164-0010
866-859-6060
<http://www.genworth.com/COV>



[Home](#)



[Back](#)



[Forward](#)

[Eligibility](#)

[Enrollment](#)

[Premiums](#)

[Program Options](#)

- Options Prior to January 1, 2017
- Options After January 1, 2017

[Benefit Increase Options](#)

[Benefits](#)

[Pre-Existing Conditions Limitation](#)

[Exclusions](#)

[Coordinated Coverage](#)

[Resources](#)