COV Group Voluntary Long-Term Care Insurance

VRS Employer Manual

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.

What's New?

July 1, 2025

- The Employer Manual has a new style and format.
- The Table of Contents is hyperlinked on each page. Click "Table of Contents" to expand. Click "Table of Contents" and drag in any direction to collapse.

Table of Contents

Eligibility

The following employees, members and retirees are eligible to apply for the COV Voluntary Group Long-Term Care Insurance Program:

- State employees who average 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 average at least 20 hours a week; employees do not have to be VRS members;
- School division employees or political subdivision employees who average 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 five years or more of VRS-covered service;
- Retirees under age 75 receiving a VRS-administered benefit;
- Retirees of a Virginia public college or university who are under age 75.

If the applicant is a deferred VRS member or retiree, the employer is not required to have elected the program.

Family members may also apply for coverage if they are between the ages of 18 and 75 and undergo full evidence of insurability screenings. 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.

Enrollment

To enroll in the program, applicants should visit the Genworth Life website and fill out an online application. Applicants will receive a confirmation email after their information has been received.

Evidence of insurability is reduced if the applicant is age 65 and under and applies within 60 days of employment. Full evidence of insurability will be required after 60 days or if the applicant is over age 65. Full evidence of insurability is required for any family members who apply, or if the applicant is a VRS deferred member or retiree. Evidence of insurability 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 participant and may be automatically deducted from a checking or savings account on a monthly, quarterly, semi-annual or annual basis.

Program Options

During enrollment, an applicant chooses three elements: the monthly benefit, the total coverage amount and the benefit increase option. The amount of each varies, depending on the date of enrollment. Participants enrolled before January 1, 2017 are entitled to the program options outlined in the Options Prior to January 1, 2017 section below. Participants enrolled after this date are entitled to the program options outlined in the Options After January 1, 2017 section below.

Options Prior to January 1, 2017

The monthly benefit is the maximum amount the plan covers for qualifying long-term care expenses each month. Applicants selected one of the following options:

- $3,000
- $4,500
- $7,500

Once the monthly benefit amount was selected, applicants chose 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 were:

- 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.

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

The table above shows the monthly benefit choices and the corresponding total coverage amounts (maximum lifetime benefit options).

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 applicant 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.

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

The table above shows the monthly benefit choices and the corresponding total coverage amounts (maximum lifetime benefit options).

If the selected monthly benefit amount is $3,000, the applicant can choose total coverage (maximum lifetime benefit amount) of $72,000, $108,000 or $144,000.

Benefit Increase Options

In addition to choosing a monthly benefit and maximum lifetime benefit option, an applicant 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 a participant 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 participant selects. Evidence of insurability 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 participant is chronically ill or eligible for claim on the date the offer is accepted.

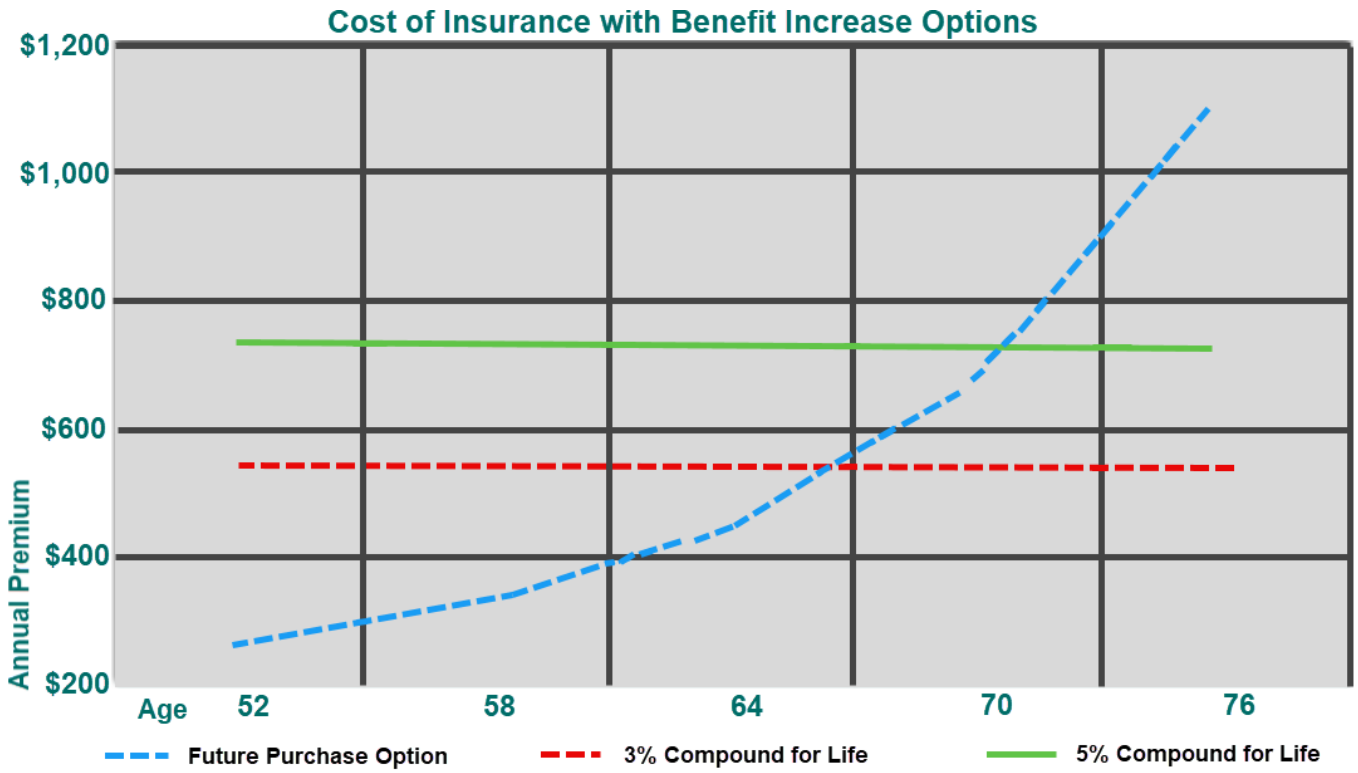
The Future Purchase Option allows for lower premiums today than what is provided with other benefit increase choices. The participant chooses when to increase coverage based on individual needs at the time of the offer. However, the premiums are based on the participant's age at the time the offer is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

Under the 3% Compound for Life option, the monthly benefit and total coverage amount (less any claims paid) automatically increases 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 insurability 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 insurability 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.

EXAMPLE

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 participant elects the increase offer every sixth year.



Benefits

Participants may qualify for benefits if they are in need of assistance with two activities of daily living and the assistance is expected to be needed for at least 90 days. Participants may also qualify for benefits if they have a severe cognitive impairment and require supervision.

After a doctor, nurse, social worker or other appropriately licensed treating healthcare professional certifies the participant's inability to perform two activities of daily living or that the participant 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 participant 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 is 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 Disease) 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.
Informal Care Benefit	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.
Hospice Care Benefit	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.

Continued on the next page.

Continued from the previous page.

Coverage Type	Description
Respite Care	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.
Alternate Care Benefit	Services, devices or treatments not otherwise payable under the plan that Genworth has determined are cost-effective, appropriate to the participant'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 participant'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.

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.

Exclusions

The plan will not pay benefits for any expenses incurred for any covered care:

- For which no charge is normally made in the absence of insurance;
- Provided outside the United States, the District of Columbia and any territory or possession of the United States of America, unless specifically provided for by a benefit;
- Provided by an insured's immediate family, unless a benefit specifically states that a member of an insured's immediate family can provide covered care. The plan does not consider care to have been provided by a member of the insured's immediate family when:
  - ◊ The family member is a regular employee of the organization that is providing the services; and
  - ◊ Such organization received payment for the services; and
  - ◊ The family member receives no compensation other than the normal compensation for employees in their job category.
- Provided by or in a Veteran's Administration or federal government facility, unless a valid charge is made to an insured or an insured's estate;
- Provided for an insured's alcoholism or addiction to drugs or narcotics (except for an addiction to a prescription medication when administered in accordance with the advice of a physician);
- Resulting from illness, treatment or medical condition arising out of any of the following:
  - ◊ War or any act of war; whether declared or not;
  - ◊ Attempted suicide or an intentionally self-inflicted injury;
  - ◊ Participation in a felony; riot or insurrection.

The plan will pay benefits for Alzheimer's Disease, subject to the same exclusions, limitations and provisions otherwise applicable to other covered care.

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 additional coverage.

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

Resources

For information and downloadable materials, visit the COV Voluntary Group Long-Term Care Insurance Program page on the VRS employer website. For additional information, contact Genworth Life directly:

Genworth Life Insurance Company
866-859-6060
Group Processing Center; P.O Box 64010; St. Paul, MN 55164-0010