

PIBT ADMINISTRATIVE GUIDELINES FOR EMPLOYER GROUPS

HOW DOES A COMPANY ADD A NEW EMPLOYEE?

All full time employees working 30 hours or more a week are eligible the first of the month following the specified waiting period your company has chosen. The employer is required to pay 75% of the least expensive plan selected from PIBT's Member Participation Agreement. Please complete and submit an enrollment form to PIBT paying particular attention to name, address, ss# & full-time hire date. Your employee will receive their ID card from the carrier once the enrollment form has been processed. Also PIBT will issue a "Help Card" to the employee's home address to assist them when calling PIBT.

Submit the enrollment form at least **three full weeks** before the appropriate effective date. This avoids having the member use the benefits before the enrollment form has been acknowledged as received. If the enrollment form is not submitted to PIBT within 30 days from the applicable effective date (see the chart below), the form will be rejected as a late enrollment and returned to you. You may, of course, resubmit during open enrollment (December and January).

Employees who wish to waive coverage may do so upon initial enrollment. A waiver form must be completed at that time and sent to PIBT. However, the employee and/or dependents may be added thereafter during open enrollment (December and January) or in the event of lifestyle changes (e.g. marriage, birth or adoption) or loss of coverage, as long as appropriate documentation is provided within the defined time period.

WHAT IS THE COMPANY'S WAITING PERIOD?

The waiting period is the amount of time a new employee must wait before being eligible for enrollment onto a health care plan. The waiting period applies to all new employees. The company chooses from making the length of the waiting period listed on the "Member Participation Agreement". All full time employees are eligible the first of the month following the specified waiting period.

Waiting periods cannot be waived or modified on a per employee basis

For example:	<u>Hire Date</u>	<u>Waiting Period</u>	<u>Effective Date</u>
	January 1 st	One Month	February 1 st
	January 4 th	Two Months	April 1 st
	January 15 th	Three Months	May 1 st

It is the employer's responsibility to offer the health insurance benefits to an employee who has met the chosen waiting period.

WHAT ABOUT DEPENDENT ADDITIONS?

Newborn – To add a newborn to your policy, a completed/signed enrollment form along with proof of birth must be submitted to PIBT within 30 days from the newborns date of birth. If the Enrollment Form is not submitted within the first 30 days of birth the newborn may only be added thereafter during Open Enrollment (December – January).

Dependent Child – An eligible dependent child is the unmarried child under 19 years old of either the employee or spouse. A child may remain a dependent if he/she is enrolled as a full time student (12 units) at an accredited institution of higher learning (subject to specific plan rules). A child may be added at initial employee enrollment, during open enrollment (December and January), when the Court Orders the employee to provide coverage, or when the Court awards legal adoption to the member. A completed/signed Enrollment Form and a copy of the Court Order are required when enrolling dependent children in such instances.

Family – Families may be added at initial employee enrollment or during Open Enrollment (December – January). However, families can be added in the event of lifestyle changes (e.g. marriage, birth or adoption) or loss of other coverage, as long as appropriate documentation is provided within defined time period.

Spouse – A spouse is an adult who is legally married to the employee. A spouse may be added at the initial employee enrollment or Open Enrollment (December – January). A new spouse must be added within 30 days of the marriage date. In order to become effective on the date of marriage a completed/signed enrollment form and a copy of the marriage certificate are required.

Domestic Partner – A domestic partner (DP) is defined to be in a domestic partnership and subject to meeting and registering the “Declaration of Domestic Partnership” form LP/SF DP-1. A completed/signed enrollment form and a copy of the executed “Declaration of Domestic Partnership” form must be submitted to PIBT within 30 days from the registration date. If the enrollment form and “Declaration of Domestic Partnership” form are not submitted within the specified time frame coverage can only be added during Open Enrollment (December – January).

* Please Note: ***Coverage is never automatic; an enrollment form and pertaining documentation is always required.***

CAN HEALTH PLANS BE CHANGED?

Plan changes are allowed only during Open Enrollment (December – January). If an employer offers more than one plan option, and an employee wants to switch from one Health Carrier to another, (e.g. Kaiser to Blue Shield, or Cigna to Health Net) this can only be done during Open Enrollment (December – January). This rule applies to all medical and ancillary plans.

WHAT ABOUT PRE-EXISTING CONDITIONS?

Pre-existing condition applies to PPO Plans only. If you are presently enrolled in a PIBT plan and are simply changing plans, the pre-existing condition clause does not apply. However, if you are a new enrollee, a Certificate of Creditable Coverage (also known as a HIPAA letter) showing proof of prior coverage will reduce the pre-existing condition clause by one month for each *continuous* month of coverage under the previous health insurance carrier. If you have been covered for more than 6 continuous months, the pre-existing condition clause can be waived by submitting the certificate of credible coverage to the new carrier.

CAN EMPLOYER PLAN SELECTION INCLUDE DIFFERENT CARRIERS?

Yes, in most instances. However, due to carrier contracts, Health Net PPO and POS Plans cannot be offered by any company offering a Blue Shield PPO, POS and HMO Plan unless the company offered both Health Net and Blue Shield prior to November 1, 2001. There is also a PPO and POS restriction based on employer size. Please call for details.

HOW DO TERMINATIONS OR CHANGES TO EMPLOYEE'S COVERAGE GET REPORTED?

The employer is responsible to report coverage termination within 30 days from employment termination date. A dated PIBT Termination/Change form must be completed and should include the employee's full name, employee PIBT ID number, actual date of employment termination, and employer's signature. Please specify the types of coverage affected (medical, dental, vision, chiropractic, life, etc.). PIBT allows retroactive refund of premium for terminated employees for a maximum of 30 days from the date of notification. Employee terminations are effective at the end of the month in which the employee was terminated. Terminations will be reflected on the next monthly premium invoice providing the written request arrives in our office by the 20th of the month. Terminations received after the 20th of the month will be issued as credits on the subsequent months invoice.

WILL PIBT MAIL COBRA OR STATE CONTINUATION NOTICES TO TERMINATED EMPLOYEES AND/OR DEPENDENTS?

Yes, as an additional service to our employers, PIBT will mail out the required notice of COBRA rights (for employers with 20 or more employees) or CAL COBRA rights (for employers with 2 to 19 employees). This process will be triggered by the termination of an employee, spouse or dependent child (over age dependent child termination is automatic unless full time student status has been established) by the employer using the process covered in the previous section. Since the Law requires timely notification, it is critical that terminations be reported within 30 days of the termination date. If COBRA or State Continuation Coverage is elected PIBT will coordinate with the COBRA or CAL COBRA participant directly. Employers will not be responsible for collection of premiums.

WHAT ABOUT EMPLOYEES WITH LIFE INSURANCE WHO ARE NOT ACTIVELY AT WORK?

The life insurance plans available through PIBT exclude payment of a death claim when it is determined that the deceased employee was not in active status. To avoid such a denial, be aware that when enrolling or at the time a death claim is submitted, the employee must be considered a paid full time employee performing all material duties of his/her occupation whether performed at the employer's usual place of business or some other location which is usual for the employee's particular duties. Remember, death claims are not automatically paid just because premiums payments have been made. Familiarity with the life insurance plan's limitations and exclusions is vital. If your employee becomes totally disabled there is a provision for Waiver of Premium that is available on all life insurance plans offered by PIBT for employees who remain totally disabled and are under the age of 65. This means that, upon approval, coverage is maintained without payment of premiums. Waiver of Premium claim forms, including attending physician's statement, must be submitted to the insurance carrier within the specified period of time. Contact your PIBT Team Lead or Relationship Keeper to review important details and instructions.

WHERE DO I GET PIBT FORMS?

Enrollment Forms, Termination/Waiver/Change forms, Fulltime Student certification, Summary of Plan Benefits, Evidence of Coverage, etc. are available on our website.

For Southern California & San Diego: <http://www.piasc.org/pages/PIASCforms.html>

For Northern California: <http://www.piasc.org/pages/PINCforms.html>

For Georgia: <http://www.piasc.org/pages/PIAGforms.html>

WHERE CAN I VERIFY IF A SPECIFIC PROVIDER IS PART OF THE NETWORK?

From the carrier websites listed below:

Medical	Blue Shield PPO, HMO and POS CIGNA HMO Health Net PPO, HMO and POS Kaiser HMO AETNA	www.blueshieldca.com www.cigna.com www.healthnet.com www.kaiserpermanente.org www.aetna.com
Dental	Blue Shield Dental DMO CIGNA Dental DMO SafeGuard Dental DMO Humana Dental DPO Western Dental DMO AETNA	www.blueshieldca.com www.cigna.com www.safeguard.net www.humanadental.com www.westerndental.com www.aetna.com
Vision	Vision Service Plan VSP I & VSP II Vision Indemnity EyeMed	www.vsp.com www.piasc.org www.eyemedvisioncare.com
Chiropractic	Landmark	www.landmarkhealthcare.com
Mental Health	MHN	www.members.mhn.com

WHEN DO I GET BILLED FOR PREMIUMS?

Your employee benefits are prepaid. Premium invoices are mailed on the first of the month for that current month. Your premium statement will reflect details of employees, by listing their identification number, name, sex, age, description of benefit, amount due per plan individual, as well as your total premium due. For PIASC and PIAG members, Association Dues are included. Remittance address appears on each statement. Please review your bill carefully and notify PIBT immediately of any discrepancies. It is the employer's responsibility to promptly review the monthly premium invoice and report any corrections/changes to our office.

WHEN IS PREMIUM PAYMENT DUE?

Payments are due on or before the 10th of each month for the month in which coverage is granted. A 10 day grace period may be extended. However, if payment is not post marked on or before the grace period date, then coverage is subject to cancellation.

WHERE DO I SEND PREMIUM PAYMENTS?

PAYMENTS should be mailed to the PIBT lockbox:

**PIBT
P.O. BOX 513857
Los Angeles, CA 90051-3857**

(PLEASE **DO NOT** FED EX ANY PAYMENTS OR INCLUDE CORRESPONDENCE TO THE LOCK BOX)

WHERE DO THE MONIES HAVE TO BE RECEIVED AT BY THE DUE DATE?

The trustees of PIBT have required that all accounts are considered paid only when funds are received in PIBT's bank account at the bank address referenced on your PIBT monthly invoice.

Examples of accounts not considered paid are:

- Hand delivered checks to our physical office
- PIBT is notified that a check was returned for any reason (i.e.*NSF, Stopped Payment, Account Closed, etc.)

***A \$150.00 fee will be applied to your account if a check is returned as non sufficient funds.**

WHAT CONSTITUTES NON-PAYMENT?

If 10% or more of the current month invoice amount in the "Total Now Due" line is outstanding, then your account is in a non-payment status (i.e. if "Total Now Due" is \$1000 and only \$895 is received, the account will be considered in a non-payment status). If payment is not received by the end of the grace period, coverage will be cancelled for non-payment and a **Confirmation of Coverage Termination** notice will be sent.

IS REINSTATEMENT OF COVERAGE EVER POSSIBLE?

Reinstatement of coverage is never guaranteed and is always subject to guidelines set by PIBT trustees and to Management review. Review for reinstatement may only be considered if written request is received at PIBT within 5 days from the date the Confirmation of Coverage Termination notice is sent. ***If reinstatement is granted a \$500 reinstatement fee plus all premiums due, including the current months premiums, must be received within 2 business days after approval at our physical address:***

**PIBT
5800 S. Eastern Avenue, Suite 400
Los Angeles, CA 90040**

WHAT IF CANCELLATION HAPPENS MORE THAN ONCE IN A CALENDAR YEAR?

PIBT is a benefit trust and as such holds premiums in trust for the benefit of members who have paid. PIBT must remit these premiums according to the terms and conditions of coverage contracts. Due to this, reinstatement is granted as a courtesy and will not be considered more than once in a 12 month period.

WHEN MUST CHANGES TO MY ACCOUNT BE RECEIVED SO THAT WE WILL NOT BE HELD RESPONSIBLE?

Unlike commercial insurance carriers who invoice in advance of providing coverage, PIBT premiums are invoiced on the first business day of every month for active coverage. Thus coverage is provided even if premium has not been received. PIBT depends on our participating members to keep eligibility up to date. It is extremely important to notify PIBT of any changes to your invoice immediately. This allows PIBT to notify carriers promptly and internally note your account accordingly.

WHO DO I CALL FOR ADDITIONAL ASSISTANCE?

When you have questions on your monthly premium statement, eligibility issues or general group health questions, call our Customer Service Department. We have assigned specific Relationship Keeper's (RK's) from the Benefit Trust to each account on an alphabetical basis. Please note the following individuals and their extension numbers.

Our **PIBT** phone number is **(323) 728-9500**. For employers outside Southern California our phone number is **(800) 449-4898**. Or send an e-mail to your assigned Relationship Keeper (RK). Please specify your Employer Name and Employer ID# located on your monthly invoice.

Team Lead & Relationship Keeper	Extension	Companies beginning with the letter:	E-mail	Languages Spoken
Anna Acuña	240	Team Lead	anna@piasc.org	English and Spanish
Sandra Bonilla	258	A, B, C, D	sandra@piasc.org	English
Denise Holguin	226	E, F,G,H,I J, K,L M	denise@piasc.org	English
Mario Geraci	227	Team Lead	mario@piasc.org	English
Carlos Sanmiguel	239	Q, R, S, T, U, V, W, X, Y, Z	carlos@piasc.org	English and Spanish
Olga Cuellar	250	N, O, P and Georgia Accts.	olga@piasc.org	English
Evie Bañaga	224	Team Lead Major Accounts	evie@piasc.org	English and Spanish
Jessica Munguia	225	Asst. Major Accounts	jessica@piasc.org	English and Spanish
Lisa Gutierrez	246	COBRA Accounts	lisa@piasc.org	English

Our number one goal is to provide you with the best customer service.

If any question is not answered to your satisfaction or you have any concerns we want to hear from you. Please call:

In Northern California:	Dan Nelson, PINC President	Ph. (415) 495-8242	E-mail: dan@pinc.org
In Southern California:	Bob Lindgren, PIASC President	Ph. (323) 728-9500	E-mail: bob@piasc.org
In San Diego:	Karen Fulton, PIASD President	Ph. (858) 571-6555	E-mail: karen@piasd.org
In Georgia:	Timothy Taylor, PIAG President	Ph. (770) 433-3050	E-mail: ttaylor@piag.org