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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 50% of the least expensive plan selected on the PIBT Member Participation Agreement. Please complete and submit an enrollment form to PIBT paying particular attention to name, address, Social Security Number, and full-time hire date. Your employee will receive a health care ID card from the carrier once the enrollment form has been processed. In addition, PIBT will send 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 dependent(s) may be added thereafter during Open Enrollment or in the event of lifestyle changes (e.g. marriage, birth/adoption) or loss of coverage, as long as appropriate documentation is provided within the defined time period.

WHAT IS THE COMPANY 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 and re-hired employees. The company chooses 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 all eligible employees meeting the selected waiting period.

WHAT ABOUT DEPENDENT ADDITIONS?

Newborn – To add a newborn to your policy, a completed and signed enrollment form along with proof of birth must be submitted to PIBT within 30 days from the newborn 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.

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 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), when the Court Orders the employee to provide coverage, or when the Court awards legal adoption to the member. A completed and signed enrollment form along with a copy of the Court Order is required when enrolling dependent children in such instances. Compliance to Court Order of adding dependent (s) can only be done in conjunction with employee having coverage.

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 (HIPAA Creditable Coverage) 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 marriage date. In order for coverage to become effective on the marriage date, a completed and signed enrollment form along with a copy of the marriage certificate is 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 NP/SF DP-1. A completed and 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 defined time period, coverage can only be added during Open Enrollment (December – January).

IMPORTANT: 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. 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 and must submit a new enrollment form. 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.

(*) Required number of units differs by carrier.

CAN EMPLOYER PLAN SELECTION INCLUDE DIFFERENT CARRIERS?

Yes, in most instances. However, due to carrier contracts, if you are offering a Health Net Silver HMO Plan, you may not offer any Health Net HMO Plan or Health Net EOA Plan.

HOW DO TERMINATIONS TO EMPLOYEE'S COVERAGE GET REPORTED?

The employer is responsible to report all coverage terminations to PIBT within 30 days from the date of employment termination. A PIBT Termination/Waiver form (ER-06) needs to be fully completed and signed by the company representative. Be sure to include the employee's full name, current home address, and PIBT ID number (as seen on your monthly invoice). PIBT allows a retroactive termination date for a maximum of 30 days. Employee terminations are effective at the end of the month in which the employee was terminated. Carefully check off all appropriate boxes beginning with "coverage type to be terminated" section. Terminations received by the 20th of each month will be reflected on the next monthly premium invoice. Terminations received after the 20th of the month will be reflected on the subsequent monthly premium 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 State Continuation Coverage rights (for employers with 2 to 19 employees). This process will be triggered by the termination of an employee, spouse and/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 State Continuation Coverage 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 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 60. This means that, upon approval, coverage is maintained without payment of premiums. Waiver of Premium claim forms, including attending physician statement, must be submitted to the insurance carrier within the specified period. 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>

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.kp.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 PIBT 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 also included. Remittance address appears on each statement, a self addressed return envelope is provided for your convenience. 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 or 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, if requested. However, if payment is not postmarked 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** FEDEX ANY PAYMENTS OR INCLUDE CORRESPONDENCE TO THE LOCKBOX)

WHERE THE MONIES MUST BE RECEIVED BY THE DUE DATE?

The PIBT Trustees consider an account paid only when all funds are received in PIBT's bank account, at the bank address referenced on your PIBT monthly premium invoice.

Examples of accounts not considered paid are:

- Hand delivered checks to our physical address
- PIBT is notified that a check was returned for any reason (i.e. NSF*, stopped payment, account closed, etc.)

****If a check is returned for non sufficient funds, a \$150.00 fee will apply and will show on your following monthly premium invoice.***

WHAT CONSTITUTES NON-PAYMENT?

If 10% or more of the "Total Now Due" amount is outstanding, then your account is in non-payment status (i.e. if "Total Now Due" is \$1,000 and PIBT receives only \$895, the account will be in non-payment status). PIBT must receive full payment by the end of the grace period to avoid cancellation of coverage for non-payment. Once coverage is cancelled, 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. Reinstatement might be considered if PIBT receives a written request within 5 days from the date the Confirmation of Coverage Termination notice is sent. ***If reinstatement is granted an applicable \$500 reinstatement fee plus all premiums due, including the current month premiums, must be received within 2 business days after reinstatement 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 COVERAGE CHANGES BE RECEIVED SO THAT WE WILL NOT BE HELD RESPONSIBLE?

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

