

PIBT ADMINISTRATIVE GUIDELINES FOR EMPLOYER GROUPS

HOW DOES A COMPANY ADD A NEW EMPLOYEE?

Please submit the new employee's completed enrollment form to PIBT, paying particular attention to the employee's name, social security number, date of birth, address and full-time hire date. Your employee will receive a health insurance 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 for use when calling PIBT for assistance. 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. As the employer, you are required to pay 50% of the employee's monthly premium of the least expensive plan selected from the PIBT Member Participation Agreement form. **(Note: all forms referenced on this "Administrative Guidelines" are available on our website)**

Submit the enrollment form at least **three full weeks** before the appropriate effective date. This avoids having the employee utilizing services before the enrollment form has been acknowledged as received and benefits become effective. If the enrollment form is not submitted to PIBT within 30 days from the applicable effective date, (see "For example" below), the enrollment form will be rejected as a late enrollment and returned to the employer.

Employees who wish to waive coverage may do so upon initial enrollment. A PIBT waiver form must be completed at that time and sent to PIBT. In addition to the initial enrollment, the employee and/or dependents may be added thereafter during **Open Enrollment** (December- January) or in the event of a **lifestyle change** (e.g. birth, adoption, marriage or registration of domestic partnership) or at the time of the **loss of coverage**. Appropriate documentation must also be provided within the defined time period of 30 days.

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 employees meeting the selected waiting period.

WHAT ABOUT WAITING PERIODS FOR RE-HIRED EMPLOYEES?

When re-hired within 30 days from termination date, the employee will be reinstated without the waiting period being applied, with no lapse in coverage. If the employee is rehired after 30 days from the termination date then the company's waiting period will apply and there will be a lapse in coverage.

WHAT ABOUT DEPENDENT ADDITIONS?

Dependent Child- *An eligible dependent child is the child (under 26 years old) of either the employee or spouse.* A child may be added at the **initial employee enrollment** time or during **Open Enrollment** (December- January), or when **loss of coverage occurs** by submitting a completed and signed PIBT enrollment form. In cases of **loss of coverage**, the PIBT enrollment form must be submitted within 30 days from loss of coverage along with a copy of the Certificate of Creditable Coverage letter from the previous insurance carrier. When a **court orders** an employee to provide coverage, or when a court awards **legal adoption** to the employee, a completed and signed PIBT enrollment form along with a copy of the Court Order is required when enrolling dependent children in such instances. Proof of adoption will always be required and must be submitted within 30 days of the placement. Once all pertinent forms and documentation has been received, PIBT will begin billing the first day of the month following the **loss of coverage** or **lifestyle change**.

Domestic Partner- *A domestic partner is an adult in a legally registered domestic partnership.* A domestic partner may be added at **initial employee enrollment** time or during **Open Enrollment** (December-January) or when **loss of coverage** occurs by submitting a completed and signed PIBT enrollment form. The registration date of the domestic partnership must appear on the PIBT enrollment form. A newly registered domestic partnership's enrollment form must be received within 30 days from **loss of coverage** along with a copy of the Certificate of Creditable Coverage letter from the previous insurance carrier. Once, all pertinent forms and documentation have been received, PIBT will begin billing the first day of the month following the **loss of coverage** or **lifestyle change**.

Family- *Family members are dependents of the subscriber, who meet eligibility requirements for coverage and have been enrolled.* Family coverage may be added at **initial employee enrollment** time or during **Open Enrollment** (December-January). Also, family coverage can be added in the event of **lifestyle changes** (e.g. marriage, birth or adoption) or **loss of coverage**. In cases of **loss of coverage**, the PIBT enrollment form must be submitted within 30 days from **loss of coverage** along with a copy of the Certificate of Creditable Coverage letter from the previous insurance carrier. Once all pertinent forms and documentation has been received, PIBT will begin billing the first day of the month following the **loss of coverage** or **lifestyle change**.

Newborn- When applying for coverage, the birth of your child is considered a **lifestyle change**. To add your newborn child to your existing insurance coverage, a completed and signed PIBT enrollment form along with proof of birth (e.g. hospital live birth certification or birth certificate) must be submitted to PIBT within 30 days from the newborn's date of birth. If the PIBT enrollment form is not submitted within the first 30 days of birth, the newborn may only be added thereafter during **Open Enrollment** (December-January). Once all pertinent forms and documentation has been received, PIBT will begin billing the first day of the month following the **loss of coverage** or **lifestyle change**.

Spouse- *A spouse is an adult who is legally married to the employee.* A spouse may be added at **initial employee enrollment** time during **Open Enrollment** (December- January) or when **loss of coverage** occurs, by submitting a completed and signed enrollment form. In cases of **loss of coverage**, the enrollment form must be submitted within 30 days from **loss of coverage** along with a copy of the Certificate of Creditable Coverage letter from the previous insurance carrier. The date of marriage must appear on the PIBT enrollment form. A PIBT enrollment form must be received within 30 days from the date of marriage. Once all the pertinent forms and documentation has been received, PIBT will begin billing the first of the month following the **loss of coverage** or **lifestyle change**.

PIBT will begin billing the first day of the month following any of the lifestyle change/events, unless the lifestyle change/events are on the 1st of the month, at which time the billing will begin as of that month.

IMPORTANT: Coverage is never automatic; a PIBT enrollment form and pertaining documentation are always required.

CAN HEALTH PLANS BE CHANGED AT ANY TIME?

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, HealthNet to Kaiser) this can only be done during Open Enrollment (December – January). Enrollment forms are required to be completed and submitted to PIBT for all plan changes. This rule applies to all medical and ancillary plans.

CAN EMPLOYER PLAN SELECTION INCLUDE DIFFERENT CARRIERS?

Yes, in most instances. However, due to carrier contracts there are some exceptions. For example if an employer is offering a Health Net Silver or Health Net Bronze plan, you cannot offer any Health Net full network HMO or EOA plans. For Blue Shield, if you are offering Local Access plans (Local Access HMO 20 Value or Local HMO 30) these cannot be offered with any Blue Shield HMO plans.

HOW DO TERMINATIONS TO EMPLOYEE'S COVERAGE GET REPORTED?

The employer is responsible to report all coverage terminations to PIBT within 30 days from employment termination date. 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 who select PIBT as their COBRA Administrator (see PIBT Employer Participation Agreement), 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 or dependent child 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 qualified beneficiary 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 65. 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?

All PIBT forms are available on our website:

(Enrollment/Termination/Waiver/Change forms, Summary of Plan Benefits, Evidence of Coverage, etc ;)

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

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

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

You can reach the following carriers below by calling the customer service phone numbers or logging onto their website.

Medical	Blue Shield PPO, HMO and POS- (888)235-1765 Health Net PPO, HMO and POS- (800)361-3366 Kaiser HMO - (800)464-4000 Kaiser Deductible HMO - (800)390-3507	www.blueshieldca.com www.healthnet.com www.kp.org www.kp.org
Dental	Blue Shield Dental DMO- (800)585-8111 CIGNA Dental DMO- (800) 367-1037 Western Dental DMO- (800) 992-3366 Humana Dental DPO/DMO PPO- (800) 233-4013 DMO-(888) 200-5022	www.blueshieldca.com www.cigna.com www.westerndental.com www.humanadental.com
Vision	Vision Service Plan VSP I & VSP II- (800)877-7195 Vision Indemnity- (323)728-9500 EyeMed- (800) 334-7591	www.vsp.com www.piasc.org www.eyemedvisioncare.com
Chiropractic	Landmark- (800)638-4557	www.landmarkhealthcare.com
Mental Health	MHN- (800) 777-9355	www.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, effective date, status of coverage, type of coverage, benefit description, and itemized premium per employee. 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 PIBT.

WHEN IS PREMIUM PAYMENT DUE?

Payments are due on the **1st** of each month and past due by the **10th**. A 30 day grace period is provided as required by law. However, if payment is not postmarked on or before the grace period end date, then coverage is subject to cancellation.

You may request a review by the California Insurance Commissioner if you believe your health insurance policy or coverage has been or will be wrongly canceled, rescinded or not renewed. To do so, you must, as soon as possible, submit your request for review in writing to: California Department of Insurance, Consumer Communications Bureau, 300 S. Spring Street, South Tower, Los Angeles, California, 90013 or through the website: <http://www.insurance.ca.gov>. You may contact the California Insurance Commissioner's Consumer Communications Bureau at 1-800-927-HELP(4357) or TDD 1-800-482-4833 for information about how to request a review in writing. It will be to your advantage if you are able to provide the Department with your health insurance policy number, copies of any letters you have received from us or a copy of your health insurance card.

As soon as we receive notice from the Department of Insurance that you have requested a review by the commissioner, we must continue to provide coverage as of the date you requested the review until a final determination of your request for review has been made by the commissioner, unless your policy or coverage is being cancelled for nonpayment of premiums. To ensure that your coverage is continued without interruption, you must request a review by the commissioner before your coverage ends.

In the event the commissioner determines that your request for review is a proper complaint and, subsequently, that the cancellation, rescission or nonrenewal was unlawful, the commissioner shall order us to reinstate your coverage, retroactive to the time of cancellation, rescission or nonrenewal.

WARNING: You must continue to pay your insurance premiums on time in order to maintain coverage, and if your coverage is reinstated retroactively you will be responsible for paying insurance premiums corresponding to any gap in coverage between the time your coverage was terminated and the time it was continued or reinstated.

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)

If you need to overnight a payment to PIBT please direct it to our physical address:

**PIBT
5800 South Eastern Avenue Suite 400
Los Angeles, Ca. 90040**

WHERE THE MONIES MUST BE RECEIVED BY THE DUE DATE?

The PIBT Trustees consider an account paid only when 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 to the employer.

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 bills 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.

WHO DO I CALL FOR ADDITIONAL ASSISTANCE?

When you have questions on your monthly premium invoice, eligibility issues or general group health plan 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.

Phone numbers: **(323) 728-9500** for employers located in Los Angeles area
(800) 449-4898 for employers located outside of the Los Angeles area

Fax numbers: **(323) 722-7386** for employers located in Los Angeles area
(866) 559-0335 for employees located outside of the Los Angeles area

Website: www.piasc.org

PIBT'S EMAIL ADDRESS

To streamline the process of enrollments and changes you can also email our PIBT Data department. The email must be password protected with the same number each time. The default password will be number 49298.

Data Department email address: pibt@piasc.org Password: 49298

LIST OF PIBT CONTACTS FOR ASSISTANCE

Look at the following list for your assigned RK, their phone extension number, and e-mail address. To help us provide you a better service when you contact us, please specify you're Employer Name and Employer ID Number located on your monthly premium invoice.

Team Lead & Relationship Keeper Spoken	Extension	Companies beginning with the letter:	E-mail	Languages
Anna Acuña	240	Team Lead	anna@piasc.org	English and Spanish
Sandra Bonilla	258	A-G	sandra@piasc.org	English
Mario Geraci	227	Team Lead	mario@piasc.org	English
Denise Holguin	239	H-Q	denise@piasc.org	English
Olga Cuellar	250	R-Z	olga@piasc.org	English
Evie Bañaga	224	Team Lead (Major Accounts)	evie@piasc.org	English and Spanish
Carlos Sanmiguel	226	A-H	carlos@piasc.org	English and Spanish
Jessica Munguia	225	I-Z	jessica@piasc.org	English and Spanish
Lisa Gutierrez	246	COBRA	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 contact:

Joanne Cadenas PIBT Operations Manager Ph.(323)728-9500 E-mail:joanne@piasc.org

You may also contact your local Association office:

In Northern California:

Dan Nelson, VMA President Ph. (415) 495-8242 E-mail: dan@vma.bz

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 Email: karen@piasd.org