

# **An Employee's Guide to Cal-COBRA Health Benefits Continuation**

***Important Information and Disclosures  
Regarding Your Health Benefits  
Continuation Coverage***

***Please read this booklet carefully***

# Table of Contents

<b>Introduction</b>	Page 3
<b>What Is Cal- COBRA Continuation Coverage?</b>	Page 3
> Summary of Qualifying Events, Qualified Beneficiaries, and Maximum Periods of Continuation Coverage	Page 4
<b>California Health Benefit Continuation</b>	Page 4
> Domestic Partners Rights under Cal-COBRA	Page 4
> Expanding Federal COBRA through Cal-COBRA Continuation Benefits	Page 4
<b>California- Health and Welfare Agency Notices</b>	Page 5
> Notice to Terminated Employees	Page 5
> Notice for Persons Disabled by HIV/AIDS	Page 5
<b>Eligible Benefits under State Mandated Health Benefits</b>	Page 6
<b>Alternatives to State Mandated Health Benefits Continuation Coverage</b>	Page 7
<b>Who Is Entitled to Continuation Coverage?</b>	Page 8
<b>Qualifying Events</b>	Page 8
<b>Qualified Beneficiaries</b>	Page 9
<b>Your State Mandated Health Benefits Rights and Responsibilities</b>	Page 9
> Notice and Election Procedures	Page 9
> Summary Plan Description	Page 9
> State Mandated Health Benefits General Notice	Page 9
> Qualifying Event Notices	Page 10
> Election Notice	Page 11
> Notice of Early Termination of Continuation Coverage	Page 11
> Election Procedures	Page 11
> Benefits under Continuation Coverage	Page 11
<b>Duration of Continuation Coverage</b>	Page 12
> Maximum Periods	Page 12
> Early Termination	Page 12
> Notice of Medical Conversion Privilege after State Continuation Coverage	Page 13
<b>Paying for Continuation Coverage</b>	Page 13
<b>Coordination with Other Federal Benefit Laws</b>	Page 14
<b>Resource/Information</b>	Page 15
<b>Election/Enrollment Forms</b>	Page 15

## *Cal-COBRA Health Benefits Continuation*

# Table of Contents

> Premium Payment Rules	Page 16
> Changes in Premiums	Page 16
> Moving Out of Your Health Plan Service Area	Page 16
> New Dependent Additions	Page 16
> Notice of HIPAA Medical Option after State Continuation Coverage	Page 17
> Continuation of Life and Long Term Disability Insurance	Page 17
> Additional Plan Documentation	Page 17
<b>Questions</b>	Page 17

## **Introduction**

Health insurance programs help workers and their families take care of their essential medical needs. These programs can be one of the most important benefits provided by an employer.

There was a time when employer-provided group health coverage was at risk if an employee was fired, changed jobs, or got divorced. That substantially changed in 1986 with the passage of the health benefit provisions in the Consolidated Omnibus Budget Reconciliation Act (COBRA). Now, many employees and their families who would lose group health coverage because of serious life events are able to continue their coverage under the employer's group health plan, at least for limited periods of time.

State Mandated Health Benefits vary from state to state. PIBT is the administrator for both Cal-COBRA and Georgia Extension. Federal COBRA is also administered by PIBT under the Federal regulations and guidelines that are different from State Mandated Health Benefits.

The right to State Mandated Health Benefits continuation coverage was created by state law. State Mandated Health Benefits continuation coverage can become available to you when you would otherwise lose your group health coverage through your current employer. It can also become available to other members of your family who are covered under the Plan when they would otherwise lose their group health coverage.

This booklet is designed to:

- Provide a general explanation of your State Mandated Health Benefits Continuation rights and responsibilities;
- Outline the State Mandated Health Benefits Continuation rules that group health plans must follow;
- Highlight your rights to benefits while you are receiving State Mandated Health Benefits Continuation coverage.

## **What Is Cal- COBRA Continuation Coverage?**

Cal-COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a “qualifying event.” Specific qualifying events are listed in this notice. After a qualifying event, Cal-COBRA continuation coverage must be offered to each person who is a “qualified beneficiary.” You, your spouse and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect Cal-COBRA continuation coverage are required to pay the coverage premiums plus a 10% administrative fee.

Cal-COBRA requires continuation coverage to be offered to covered employees, their spouses, their former spouses, domestic partners (same or opposite sex) and their dependent children when group health coverage would otherwise be lost due to certain specific events. Those events include the death of a covered employee,

termination or reduction in the hours of a covered employee's employment for reasons other than gross misconduct, divorce, or legal separation from a covered employee, a covered employee's becoming entitled to Medicare, and a child's loss of dependent status (and therefore coverage) under the plan.

While Cal-COBRA continuation coverage must be offered, it lasts only for a limited period of time. This booklet will discuss all of these provisions in more detail.

**Summary of Qualifying Events, Qualified Beneficiaries, and Maximum Periods of Continuation Coverage**

The following chart shows the specific qualifying events, the qualified beneficiaries who are entitled to elect continuation coverage, and the maximum period of continuation coverage that must be offered.

**Note that an event is a qualifying event only if it would cause the qualified beneficiary to lose coverage under the plan.**

**California Health Benefit Continuation**

Qualifying Event	Qualified Beneficiaries	Maximum Period of Continuation Coverage
Termination (for reasons other than gross misconduct) or reduction in hours of employment	Employee Spouse Dependent Child	36 months
Employee enrollment in Medicare	Spouse Dependent Child	36 months
Divorce or legal separation	Spouse Dependent Child	36 months
Death of employee	Spouse Dependent Child	36 months
Loss of "dependent child" status under the plan	Dependent Child	36 months

**Domestic Partners Rights under Cal-COBRA**

Domestic Partners same or opposite sex who have filed a Declaration of Domestic Partnership with the California Secretary of State and meet the eligibility criteria under the State of California Family Code 297 will be considered qualified beneficiaries and may elect to enroll themselves and their eligible dependent children onto Cal-COBRA. (Apply only if covered under the plan before the Qualifying Event date or loss of coverage date).

**Expanding Federal COBRA through Cal-COBRA Continuation Benefits**

California Assembly Bill, AB 1401 expanding Federal COBRA continuation benefits for California employees and their dependents took effect on January 1, 2003 and will expand coverage on July 1, 2004. Federal COBRA beneficiaries will be offered the opportunity to receive health care continuation coverage for an additional 18

months for a total of 36 months coverage by converting their Federal COBRA to a Cal-COBRA Continuation Coverage plan with an increment on the monthly premiums. In order to extend their Federal COBRA coverage under Cal-COBRA the beneficiaries must first exhaust their full-period or Federal Cobra and then notify PIBT within 30 days of when their Federal COBRA terminates.

## **California- Health and Welfare Agency Notices**

### **Notice to Terminated Employees**

The California Department of Health Services will pay the health insurance premiums for certain persons who are losing employment and have a medical condition. In order to qualify for the Health Insurance Premium Payment (HIPP) program, you must meet **ALL** of the following conditions:

1. You must currently be on Medi-Cal.
2. You must have a medical condition that has been determined by the Department of Health Care Services to be a cost effective condition for the HIPP program.
3. You must have a current health insurance policy, Cal-COBRA continuation policy, or a Cal-COBRA conversion policy in effect or available at the time of application.
4. Your health insurance policy must cover your medical condition.
5. Your application must be completed and returned in time for the State of California to process your application and pay your premium.
6. Your health insurance policy must not be issued through the California Major Risk Medical Insurance Board.
7. You must not be enrolled in a Medi-Cal related pre-paid health plan, County Health Initiative, Geographic Managed Care Program, or the County Medical Services Program (CMSP).

If an absent parent has been ordered by the court to provide your health insurance, you will not be eligible for the HIPP Program.

*For more information you may call this toll free number, 1-800-952-5294, and follow the recorded instructions.*

### **Notice for Persons Disabled by HIV/AIDS**

The Ryan White HIV/AIDS Treatment Modernization Act of 2006, formerly the Ryan White Comprehensive AIDS Resources Emergency (CARE) Act, is a federal legislation authorizing the Health Insurance Premium Payment (HIPP) program. CARE/HIPP, located within the California Department of Public Health, Office of AIDS (OA), AIDS Drug Assistance Program (ADAP) Section, pays health insurance premiums on behalf of people disabled because of HIV and the risk of losing their health insurance coverage.

CARE/HIPP provides premium payment assistance for health, dental, and vision under COBRA; Cal-COBRA; OBRA; private insurance; and HIPAA.

(Care/HIPP is *not* able to pay for insurance policies purchased through the Major Risk Medical Insurance Board)

Participants are eligible for a maximum of 36 months of coverage and must apply for State Disability Insurance, Social Security Disability Insurance, or private disability.

The following criteria must be met in order to qualify for such benefits:

- a resident of California;
- disabled by HIV/AIDS;
- have assets less than \$6,000; and
- have income less than 400 percent of federal poverty level; and

For additional information on CARE/HIPP, you may call:

**California AIDS Hotline**

1-800-367-AIDS (English/Spanish)  
1-800-922-2438 (Multi-Language)  
[www.cdph.ca.gov/programs/AIDS](http://www.cdph.ca.gov/programs/AIDS)

**DEPARTMENT OF HEALTH SERVICES**

Third Party Liability Branch  
Health Insurance Section  
P.O. Box 2471  
Sacramento, CA 95812-2471

**Eligible Benefits under State Mandated Health Benefits**

State Mandated Health Benefits Continuation generally applies to all group health plans maintained by private-sector employers with 2-19 employees. The law does not apply, however, to plans sponsored by the Federal government or by churches and certain church-related organizations.

Under State Mandated Health Benefits Continuation, a group health plan is any arrangement that an employer establishes or maintains to provide employees or their families with medical care, whether it is provided through insurance, by a health maintenance organization, out of the employer's assets on a pay-as-you-go basis, or otherwise. "Medical care" for this purpose includes:

- Inpatient and outpatient hospital care;
- Physician care;
- Surgery and other major medical benefits;
- Prescription drugs;
- Dental and vision care

Life insurance is not considered "medical care," nor is disability benefits; and State Mandated Health Benefits Continuation Coverage does not cover plans that provide only life insurance or disability benefits.

Group health plans covered by State Mandated Health Benefits Continuation Coverage that are sponsored by private-sector employers generally are governed by ERISA. ERISA gives participants and beneficiaries rights that are enforceable in court.

## **Alternatives to State Mandated Health Benefits Continuation Coverage**

If you become entitled to elect State Mandated Health Benefits continuation coverage when you otherwise would lose group health coverage under a group health plan, you should consider all options you may have to get other health coverage before you make your decision. One option may be "special enrollment" into other group health coverage.

Under the Health Insurance Portability and Accountability Act (HIPAA), if you or your dependents are losing eligibility for group health coverage, including eligibility for continuation coverage, you may have a right to special enroll (enroll without waiting until the next open season for enrollment) in other group health coverage. For example, an employee losing eligibility for group health coverage may be able to special enroll onto the spouse's plan. A dependent losing eligibility for group health coverage may be able to enroll in a different parent's group health plan. To have a special enrollment opportunity, you or your dependent must have had other health coverage when you previously declined coverage in the plan in which you now want to enroll. To special enroll, you or your dependent must request special enrollment within 60 days of the loss of other coverage. If you or your dependent chooses to elect State Mandated Health Benefits continuation coverage instead of special enrollment, you will have another opportunity to request special enrollment once you have exhausted your continuation coverage. In order to exhaust State Mandated Health Benefits continuation coverage, you or your dependent must receive the maximum period of continuation coverage available without early termination. You must request special enrollment within 60 days of the loss of continuation coverage.

Another option may be to buy an individual health insurance policy. HIPAA gives individuals who are losing group health coverage and who have at least 18 months of creditable coverage without a break in coverage of 63 days or more the right to buy individual health insurance coverage that does not impose a preexisting condition exclusion period. For this purpose, most health coverage, including State Mandated Health Benefits continuation coverage, is creditable coverage. These special rights may not be available to you if you do not elect and receive continuation coverage. For more information on your right to buy individual health insurance coverage, contact your state department of insurance.

In addition, individuals in a family may be eligible for health insurance coverage through various state programs. For more information, contact your state department of insurance.

## Who Is Entitled to Continuation Coverage?

There are three basic requirements that must be met in order for you to be entitled to elect State Mandated Health Benefits continuation coverage:

- Your group health plan must be **covered** by a state mandated health benefits law;
- A **qualifying event** must occur; and
- You must be a **qualified beneficiary** for that event

## Qualifying Events

“Qualifying events” are events that cause an individual to lose his or her group health coverage. The type of qualifying event determines who the qualified beneficiaries are for that event and the period of time that a plan must offer continuation coverage. State Mandated Health Benefits establishes only the minimum requirements for continuation coverage. A plan may always choose to provide longer periods of continuation coverage.

The following are qualifying events for a **covered employee** if they cause the covered employee to lose coverage:

- Termination of the employee's employment for any reason other than "gross misconduct"; or
- Reduction in the number of hours of employment.

The following are qualifying events for the **spouse** and **dependent child** of a covered employee if they cause the spouse or dependent child to lose coverage:

- Termination of the covered employee's employment for any reason other than "gross misconduct";
- Reduction in the hours worked by the covered employee;
- Covered employee becomes entitled to Medicare;
- Divorce or legal separation of the spouse from the covered employee; or
- Death of the covered employee.

In addition to the above, the following is a qualifying event for a **dependent child** of a covered employee if it causes the child to lose coverage:

- Loss of "dependent child" status under the plan rules.

## Qualified Beneficiaries

A qualified beneficiary is an individual who was covered by a group health plan on the day before a qualifying event occurred that caused him or her to lose coverage. Only certain individuals can become qualified beneficiaries due to a qualifying event, and the type of qualifying event determines who can become a qualified beneficiary when it happens. (See "Qualifying Events" earlier in this booklet.) A qualified beneficiary must be a covered employee, the employee's spouse or former spouse, \*domestic partners (same or opposite sex) or the employee's dependent child. In certain cases involving the bankruptcy of the employer sponsoring the plan, a retired employee, the retired employee's spouse (or former spouse), and the retired employee's dependent children may be qualified beneficiaries. In addition, any child born to or placed for adoption with a covered employee during a period of continuation coverage is automatically considered a qualified beneficiary. Agents, independent contractors, and directors who participate in the group health plan may also be qualified beneficiaries.

\* applies only to Cal-COBRA

## Your State Mandated Health Benefits Rights and Responsibilities:

### **Notice and Election Procedures**

Under State Mandated Health Benefits, group health plans must provide covered employees and their families with certain notices explaining their State Mandated Health Benefits rights. They must also have rules for how State Mandated Health Benefits continuation coverage is offered, how qualified beneficiaries may elect continuation coverage, and when it can be terminated.

### **Summary Plan Description**

The State Mandated Health Benefits rights provided under the plan must be described in the plan's summary plan description (SPD). The SPD is a written document that gives important information about the plan, including what benefits are available under the plan, the rights of participants and beneficiaries under the plan, and how the plan works. A participant or beneficiary covered under the plan may request a copy of the SPD (as well as any other plan documents), by contacting PIBT directly. These forms will be provided within 30 days of the request. Copies of these forms are also available on our website:

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

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

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

### **State Mandated Health Benefits General Notice**

Group health plans must give each employee and each spouse who becomes covered under the plan a **general notice** describing State Mandated Health Benefits rights. The general notice must be provided within the first 90 days of coverage. Group health plans can satisfy this requirement by giving you the plan's SPD within

this time period, as long as it contains the general notice information. The general notice should contain the information that you need to know in order to protect your State Mandated Health Benefits rights when you first become covered under the plan, including the name of the plan and someone you can contact for more information, a general description of the continuation coverage provided under the plan, and an explanation of any notices you must give the plan.

### **Qualifying Event Notices**

Before a group health plan must offer continuation coverage, a qualifying event must occur, and the group health plan must be notified of the qualifying event. Who must give notice of the qualifying event depends on the type of qualifying event.

The **employer** must notify the plan if the qualifying event is:

Termination or reduction in hours of employment of the covered employee;

- Death of the covered employee;
- Covered employee's becoming entitled to Medicare

The employer has 30 days after the event occurs to provide notice to the plan.

**You** (the covered employee or one of the qualified beneficiaries) must notify the plan if the qualifying event is:

- Divorce;
- Legal separation; or
- A child's loss of dependent status under the plan.

You should understand your plan's rules for how to provide notice if one of these qualifying events occurs. The plan must have procedures for how to give notice of the qualifying event, and the procedures should be described in both the general notice and the plan's SPD. The plan has 14 days from the date they are notified of the qualifying event to provide notice starting from the latest of, (1) the date on which the qualifying event occurs; (2) the date on which you lose (or would lose) coverage under the plan as a result of the qualifying event; or (3) the date on which you are informed, through the furnishing of either the SPD or the State Mandated Health Benefits general notice, of the responsibility to notify the plan and the procedures for doing so.

If your plan does not have reasonable procedures for how to give notice of a qualifying event, you can give notice by contacting the person or unit that handles your employer's employee benefits matters. If your plan is a multiemployer plan, notice can also be given to the joint board of trustees, and, if the plan is administered by an insurance company (or the benefits are provided through insurance), notice can be given to the insurance company.

## **Election Notice**

When the plan receives a notice of a qualifying event, the plan must give the qualified beneficiaries an election notice, which describes their rights to continuation coverage and how to make an election. The notice must be provided to the qualified beneficiaries within 14 days after the plan administrator receives the notice of a qualifying event. The election notice should contain all of the information you will need to understand continuation coverage and make an informed decision whether or not to elect continuation coverage. It should also give you the name of the plan's administrator and tell you how to get more information.

## **Notice of Early Termination of Continuation Coverage**

Continuation coverage must generally be made available for a maximum period 36 months or 3 months for Georgia Extension. The group health plan may terminate continuation coverage earlier, however, for any number of specific reasons. (See "Duration of Continuation Coverage" later in this booklet). When a group health plan decides to terminate continuation coverage early for any of these reasons, the plan must give the qualified beneficiary a notice of early termination. The notice must be given as soon as practicable after the decision is made, and it must describe the date coverage will terminate, the reason for termination, and any rights the qualified beneficiary may have under the plan or applicable law to elect alternative group or individual coverage, such as a right to convert to an individual policy.

## **Election Procedures**

If you become entitled to elect State Mandated Health Benefits continuation coverage, you must be given an election period of at least 60 days (starting on the later of the date you are furnished the election notice or the date you would lose coverage) to choose whether or not to elect continuation coverage.

Each of the qualified beneficiaries for a qualifying event may independently elect continuation coverage. This means that if both you and your spouse are entitled to elect continuation coverage, you each may decide separately whether to do so. The covered employee or the spouse must be allowed, however, to elect on behalf of any dependent children or on behalf of all of the qualified beneficiaries. A parent or legal guardian may elect on behalf of a minor child.

If you waive continuation coverage during the election period, you must be permitted later to revoke your waiver of coverage and to elect continuation coverage as long as you do so during the election period. Under those circumstances, the plan need only provide continuation coverage beginning on the date you revoke the waiver.

## **Benefits under Continuation Coverage**

If you elect continuation coverage, the coverage you are given must be identical to the coverage that is currently available under the plan to similarly situated active employees and their families (generally, this is the same coverage that you had immediately before the qualifying event). You will also be entitled, while receiving continuation coverage, to the same benefits, choices, and services that a similarly situated participant or beneficiary is currently receiving under the plan, such as the right during an open enrollment season to choose among available coverage options.

You will also be subject to the same rules and limits that would apply to a similarly situated participant or beneficiary, such as co-payment requirements, deductibles, and coverage limits. The plan's rules for filing benefit claims and appealing any claims denials also apply.

Any changes made to the plan's terms that apply to similarly situate active employees and their families will also apply to qualified beneficiaries receiving State Mandated Health Benefits continuation coverage. If a child is born to or adopted by a covered employee during a period of continuation coverage, the child is automatically considered to be a qualified beneficiary receiving continuation coverage. You should consult your plan for the rules that apply for adding your child to continuation coverage under those circumstances.

## **Duration of Continuation Coverage**

### **Maximum Periods**

**Cal-COBRA** requires that continuation coverage extend from the date of the qualifying event for a limited period of time 36 months.

**Georgia Extension** requires that continuation coverage extend from the date of the qualifying event for a limited period of time 3 months.

### **Early Termination**

A group health plan may terminate continuation coverage earlier than the end of the maximum period for any of the following reasons:

- Premiums are not paid in full on a timely basis;
- The employer ceases to maintain any group health plan;

A qualified beneficiary begins coverage under another group health plan after electing continuation coverage, as long as that plan doesn't impose an

- exclusion or limitation affecting a preexisting condition of the qualified beneficiary;
- A qualified beneficiary becomes entitled to Medicare benefits after electing continuation coverage; or
- A qualified beneficiary engages in conduct that would justify the plan in terminating coverage of a similarly situated participant or beneficiary not receiving continuation coverage (such as fraud).

If continuation coverage is terminated early, the plan must provide the qualified beneficiary with an early termination notice. (See "Your State Mandated Health Benefits" earlier in this booklet.)

For voluntary termination, request must be submitted in writing indicating account number, plan name, termination effective date and must be signed by the qualified beneficiary.

## **Notice of Medical Conversion Privilege after State Continuation Coverage**

All State Continuation Qualified Beneficiaries are entitled to make application for an individual plan of health insurance now or at the end of the State Continuation coverage period, as determined by the group contract. This conversion privilege is the same given to any employee or dependent spouse and/or dependent children whose coverage under the group insurance plan ceases. If the conversion privilege is exercised at the end of the continuation period, the benefits offered will be that of the conversion plan offered by the carrier in effect at the time of the conversion, not at the time of the qualifying event.

To exercise your conversion option, you must contact your insurance carrier directly to request the required application. You must then complete and return the conversion policy application and submit the required premium directly to your health insurance carrier *within 63 days* of your coverage termination

## **Paying for Continuation Coverage**

Your group health plan can require you to pay for State Mandated Health Benefits Continuation coverage. The amount charged to qualified beneficiaries under Cal-COBRA cannot exceed 110 percent of the cost to the plan for similarly situated individuals covered under the plan who have not incurred a qualifying event. In determining Cal-COBRA premiums, the plan can include the costs paid by employees and the employer, plus an additional 10 percent for administrative costs.

The 10% administrative cost **does not** apply to Georgia Extension qualifying beneficiaries.

State Mandated Health Benefits Continuation coverage charges to qualified beneficiaries may be increased if the cost to the plan increases but generally must be fixed in advance of each 12-month premium cycle. The plan must allow you to pay the required premiums on a monthly basis. The election notice should contain all of the information you need to understand the State Mandated Health Benefits Continuation coverage premiums you will have to pay, when they are due, and the consequences of late payment or nonpayment.

When you elect continuation coverage, you cannot be required to send any payment with your election form. You can be required, however, to make an initial premium payment within 45 days after the date of your election (that is the date you sign your form). Failure to make any payment within that period of time could cause you to lose all rights. The plan can set premium due dates for successive periods of coverage (after your initial payment), but it must give you the option to make monthly payments, and it must give you a 30-day grace period for payment of any premium.

You should be aware that if you do not pay a premium by the first day of a period of coverage, but pay the premium within the grace period for that period of coverage, the plan has the option to cancel your coverage until payment is received and then reinstate the coverage retroactively back to the beginning of the period of coverage. Failure to make payment in full before the end of a grace period could cause you to lose all rights.

If the amount of a payment made to the plan is wrong, but is not significantly less

than the amount due, the plan is required to notify you of the deficiency and grant a reasonable period (for this purpose, 30 days is considered reasonable) to pay the difference. The plan is not obligated to send monthly premium notices.

## **Coordination with Other Federal Benefit Laws**

The Family and Medical Leave Act (FMLA) requires an employer to maintain coverage under any "group health plan" for an employee on FMLA leave under the same conditions coverage would have been provided if the employee had continued working. Group health coverage that is provided under the FMLA during a family or medical leave is **NOT** considered State Mandated Health Benefits Continuation, and taking FMLA leave is not a qualifying event under State Mandated Health Benefits Continuation. A State Mandated Health Benefits Continuation qualifying event may occur, however, when an employer's obligation to maintain health benefits under FMLA ceases, such as when an employee taking FMLA leave decides not to return to work and notifies an employer of his or her intent not to return to work.

In considering whether to elect continuation coverage, you should take into account that maintaining group health coverage affects your future rights to protections provided under HIPAA. HIPAA limits the length of any preexisting condition exclusion that a group health plan may impose and generally requires any exclusion period to be reduced by an individual's number of days of creditable coverage that occurred without a break in coverage of 63 days or more. For this purpose, most health coverage, including State Mandated Health Benefits coverage, is creditable coverage. Electing State Mandated Health Benefits may help you avoid a 63-day break in coverage and, therefore, help you eliminate or shorten any future preexisting condition exclusion period that may be applied by a future group health plan, health insurance company, or HMO.

HIPAA also provides special enrollment rights upon the loss of group health plan coverage and rights to buy individual coverage that does not impose a preexisting condition exclusion period as described earlier in this book (See "Alternatives to State Mandated Health Benefits Continuation Coverage").

To take advantage of some of HIPAA's protections, individuals must show evidence of prior creditable coverage. The primary way individuals can evidence prior creditable coverage to reduce a preexisting condition exclusion period (or to gain other access to individual health coverage) is with a certificate of creditable coverage. HIPAA requires group health plans, health insurance companies, and HMOs to furnish a certificate of creditable coverage to an individual upon cessation of coverage. A certificate of creditable coverage must be provided automatically to individuals entitled to elect the State Mandated Health Benefits continuation coverage no later than when a notice is required to be provided for a qualifying event under State Mandated Health Benefits, and to individuals who elected State Mandated Health Benefits coverage, either within a reasonable time after learning that the State Mandated Health Benefits coverage has ceased or within a reasonable time after the end of the grace period for payment of State Mandated Health Benefits premiums. If you do not receive or you lose your certificate and cannot obtain another, you can still show prior coverage using other evidence of prior health coverage (for example, pay stubs, copies of premium payments, or other evidence of health care coverage). For more information

about evidencing prior health coverage or your rights under HIPAA, contact EBSA toll free at 1-866-444-EBSA (3272).

## **Resource/Information**

To receive more information about Cal-COBRA, you may contact the California Department of Insurance (CDI) at 1-800-927-4357 or [http://www.hmohelp.ca.gov/dmhc\\_consumer/hp/hp\\_cobra.aspx](http://www.hmohelp.ca.gov/dmhc_consumer/hp/hp_cobra.aspx)

For information about the interaction of COBRA and HIPAA, visit the EBSA Web site and click on [Your Health Plan and HIPAA...Making the Law Work for You](#).

The Centers for Medicare and Medicaid Services offer information about COBRA provisions for public-sector employees. You can write them at this address:

**Centers for Medicare and Medicaid Services**  
**7500 Security Boulevard**  
**Mail Stop C1-22-06**  
**Baltimore, MD 21244-1850**

Further information on FMLA is available from the nearest office of the Wage and Hour Division, listed in most telephone directories under U.S. Government, Department of Labor.

## **Election/Enrollment Forms**

If a covered employee or the spouse of a covered employee elects State Mandated Health Benefits Continuation Coverage and the election form does not specify who is electing coverage, the election is deemed to include an election on behalf of all who would also lose coverage due to the same qualifying event. Children of majority age in your state may complete a separate State Mandated Health Benefits Continuation Coverage Election Form in their own behalf. Please have your spouse indicate his/her election by marking the appropriate box and providing his/her signature.

**The Election Form must be completed and returned within the time limits described in your election form when received.** Failure to act within the prescribed time period will automatically result in forfeiture of all State Mandated Health Benefits Continuation Coverage privileges. A copy or faxed copy of your Election Form shall be as valid as the original. The Election Form should be returned to the following address:

PIBT  
5800 South Eastern Ave. 4<sup>th</sup> Floor  
Los Angeles, CA 90040

Completion of the Election Form *initiates* your State Mandated Health Benefits Continuation Coverage election, but does not necessarily *complete* the enrollment process. Your payment must be received within your 45 day grace period to continue with the process of your election.

## **Premium Payment Rules**

1. All payments are due the first day of each month. Coverage will be canceled if your payment is not postmarked within 30 days of the due date. Once State Mandated Health Benefits Continuation coverage is canceled, there is no option for reinstatement.
2. It is your responsibility to insure that premiums are paid in a timely fashion.
3. No late notice or reminder will ever be sent to the State Mandated Health Benefits Continuation beneficiary.
4. No reinstatement of lapsed coverage will be considered.
5. The correct account number should be listed *with* the premium payment.
6. Premiums must be paid by check or money order. Credit card and cash payments are not accepted.
7. A **\$35.00** fee will be charged for all checks returned for insufficient funds.
8. If a non-negotiable check is submitted for premium, coverage is subject to lapse with no reinstatement unless negotiable monies are delivered to PIBT within the prescribed (30 days for regular monthly premium or 45 days for the initial retroactive premium) time period.
9. All payments must be made payable to **PIBT**. DO NOT make payments to the employer or carrier offering the continuation coverage.

## **Changes in Premiums**

The premium for your State Mandated Health Benefits Continuation coverage will change based on changes in premiums paid by your former employer on behalf of similarly situated current employees and dependents. Premiums will change periodically. You will be notified in writing of any change in premium and it is your responsibility to submit the full, correct premium amount each month. You must continue to pay your current premium until you receive notification of a plan change.

**Due to employer negotiations on plan renewals, final rates are often not available until immediately prior and sometimes even after the premium due date. You will be notified as soon as final rates are determined.**

## **Moving Out of Your Health Plan Service Area**

If you are covered under a region-specific health plan (such as an HMO) and you move outside of your health plan's service area, you may be eligible to change plans if the employer providing State Mandated Health Benefits Continuation coverage maintains a plan in your new location. A change in coverage will be effective on the first day of the month following your written request for alternative coverage.

## **New Dependent Additions**

If you acquire a new dependent (due to marriage, birth or adoption) and that dependent would have qualified for group coverage if you were still covered as an employee, you may elect to add your new dependent to your State Mandated Health Benefits Continuation Coverage. You are responsible for notifying PIBT within 30 days of the formal date of marriage, birth, or adoption. After 30 days, your special option to add your new dependent expires.

## **Notice of HIPAA Medical Option after State Continuation Coverage**

As an alternative, you may seek individual medical insurance with a carrier specializing in health insurance. The Health Insurance Portability and Accountability Act (HIPAA) states that insurance carriers must offer their two most popular individual plans on a guarantee issue basis. To exercise this option you must elect State or other continuation coverage and you must exhaust that coverage. Additionally, you must have been covered under a group health insurance policy immediately prior to your HIPAA coverage application and you must not have secured any other coverage. Lastly, you must have at least 18 months of creditable coverage with no significant gap in coverage (63 days); State laws vary and may extend this time period. To inquire about HIPAA coverage, please contact any insurance carrier that offers individual plans. Certain restrictions apply to receiving this coverage.

## **Continuation of Life and Long Term Disability Insurance**

Neither life insurance nor long-term disability insurance may be continued under State Mandated health Benefits Continuation. However, if you were covered under a group life or LTD plan, you *may* be able to convert your coverage to an individual policy. The appropriate insurance company must receive written notification within 30 days of the insurance termination date. Please see your life or disability insurance certificate for further information.

## **Additional Plan Documentation**

Plan documentation is available upon written request. Please contact PIBT immediately in writing for a copy of the plan certificate documents that establish the coverage and benefits in effect prior to your loss of coverage. If you feel you do not have sufficient information to act intelligently in electing or declining State Mandated Health Benefits, please contact PIBT.

## **Questions**

All questions regarding Cal-COBRA Health Benefits Continuation Coverage should be directed to PIBT.

Phone: (323) 728-9500 ♦ (800) 449-4898 (Outside L.A. area)

Fax (323) 722-7386 ♦ (866) 559-0355 (Outside L.A. area)

Website: [www.piasc.org](http://www.piasc.org)

Printing Industries Benefit Trust will administer the requirements of the State Mandated Health Benefits Continuation law. In this capacity, PIBT provides the clerical and administrative services necessary to enable full compliance with the law.

Our mission is to serve you and the employer providing State Mandated Health Benefits Continuation coverage in the administration of this complex law's requirements. In this process you should understand that PIBT is bound in its administrative capacity by not only State law and by the insurance contract(s) through which coverage is provided. It is important to understand that neither PIBT nor the employer providing State Mandated Health Benefits Continuation coverage can deviate from or extend these legal guidelines.

PIBT has provided this State Mandated Health Benefits Continuation Rights and Rules booklet for your reference and convenience, so that you may better understand your rights and responsibilities under the law. It is intended for general information and disclosure purposes only. This brief summary cannot address all of the subtleties of the State Mandated Health Benefits Continuation law; therefore, please contact PIBT if you have a question that is not addressed in this booklet.



5800 S. Eastern Ave., Suite 400 • Los Angeles, CA 90040 • License #0747420

Phone (323) 728-9500 • Outside Southern Cal: (800) 449-4898

Fax (323) 722-7386 • Outside Southern Cal: (866) 559-0355

[www.piasc.org](http://www.piasc.org) • [www.piasd.org](http://www.piasd.org) • [www.vma.bz](http://www.vma.bz) • [www.piag.org](http://www.piag.org)