ADMINISTRATIVE GUIDELINES FOR EMPLOYER GROUPS

PIBT E-MAIL ADDRESS

To streamline the process of enrollments and changes, please e-mail all documents directly to our Data Processing Department. All documents transmitted to us must be password protected using the same default password each time.

E-mail address: pibt@piasc.org
Password: 49298

POTENTIAL LIABILITY UNDER THE AFFORDABLE CARE ACT

Effective in 2016, employers with 50 or more employees working 30 hours or more a week may be subject to penalties under the Internal Revenue Code if they do not offer qualifying health coverage to at least 95 percent of their full-time employees and their dependents. In addition, these employers may be subject to penalties under the Internal Revenue Code if the required employee contribution for self-only coverage under the lowest cost medical option exceeds 9.5% of the employee's W-2 wages for the year. Employers who may be subject to these rules should take these potential penalties into consideration when deciding which of their employees are eligible for health coverage, and how much employees will be charged for coverage. These rules are complex and there are many additional provisions that are not covered here. If you have questions about how these rules may apply to your company, you should consult with your legal counsel.

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 company's set waiting period (1 month or 2 months). As the employer, you are required to pay 50% of the employee's monthly premium of the least expensive medical plan and 50% of the monthly premium for the least expensive ancillary plan (dental, vision, chiropractic, etc.) selected on the PIBT Member Participation Agreement. Submit the new employee's completed enrollment form to PIBT. Please note: large employers (50 or more employees) may be subject to penalties under the Affordable Care Act if they do not offer coverage to a sufficient number of employees, or require an employee contribution of more than 9.5% of W-2 wages for self-only coverage under the lowest cost medical option.

When completing the PIBT enrollment form, pay particular attention to the employee's name, social security number, date of birth, address and full-time hire date. The carrier will send a health insurance ID card once the enrollment form has been processed. In addition, PIBT will send a "Help Card" for the employee to use when calling PIBT for assistance.

Submit enrollment forms at least three full weeks before the applicable effective date to avoid having the employee utilizing services before the enrollment form has been processed and benefits show active on the carrier's system. Enrollment forms not submitted to PIBT within 30 days from the applicable effective date, *(see "For example" below)*, will be rejected as a late enrollment and returned to the employer.

Employees who wish to decline coverage may do so upon initial enrollment. A PIBT Declination of Coverage form must be completed and submitted to PIBT. In addition to the initial enrollment, the employee and/or dependents may be added thereafter during Open Enrollment (December- January), in the event of a lifestyle change (birth, adoption, marriage or registration of domestic partnership), at the time of loss of other coverage or during Special Enrollment*. Documentation must be provided within the defined 30-day time period.

WHAT IS THE COMPANY WAITING PERIOD?

The waiting period is the time a new full-time employee must wait to become eligible for enrollment onto a health care plan. The waiting period applies to all ***new*** and ***re-hired*** employees. In compliance with the California 90-day maximum waiting period, PIBT has established a **1 month or 2 months waiting period** for all its group healthcare plans. Full-time employees are eligible the first of the month following the employer's elected waiting period. For Example:

Hire Date	**1 Month Waiting Period**	**Effective Date**
March 15th	April 15th	May 1st

Hire Date	**2 Months Waiting Period**	**Effective Date**
March 15th	May 15th	June 1st

The waiting period cannot be waived or modified on a per-employee-basis. It is the employer's responsibility to offer health insurance benefits to all employees meeting the applicable waiting period.

WHAT ABOUT WAITING PERIODS FOR RE-HIRED EMPLOYEES?

When re-hired within 30-days from termination date, the waiting period does not apply and the employee will be reinstated without lapse in coverage. When re-hired after 30-days from the termination date, the waiting period will apply and there will be a lapse in coverage.

WHAT ABOUT DEPENDENT ADDITIONS?

DEPENDENT CHILD — A child *(under 26 years old)* of either the employee or spouse may be added at the initial employee enrollment time, Open Enrollment (December- January), during Special Enrollment*, or loss of other coverage (copy of the Certificate of Creditable Coverage (HIPAA) letter may be required), by court order or when a court awards legal adoption or wards appointed as guardians to the employee (a copy of the court order, ward or proof of adoption will be required). PIBT enrollment form along with the required documents, if any, must be submitted within 30 days from the event date.

DOMESTIC PARTNER — An adult in a legally registered domestic partnership may be added at the initial employee enrollment time, Open Enrollment (December-January), during Special Enrollment*, or loss of other coverage (copy of the Certificate of Creditable Coverage (HIPAA) letter may be required). The domestic partnership registration date must appear on the PIBT enrollment form. PIBT enrollment form along with the required documents, if any, must be submitted within 30 days from the event date.

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, Open Enrollment (December-January), during Special Enrollment*, in the event of lifestyle changes (e.g. marriage, birth or adoption), or loss of other coverage (copy of the Certificate of Creditable Coverage (HIPAA) letter may be required). PIBT enrollment form along with the required documents, if any, must be submitted within 30 days from the event date.

NEWBORN — 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 announcement) 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), or during Special Enrollment*.

SPOUSE — A spouse is an adult legally married to the employee and may be added at initial employee enrollment time, Open Enrollment (December- January), during Special Enrollment*, or loss of other coverage (copy of the Certificate of Creditable Coverage (HIPAA) letter may be required). The date of marriage must appear on the PIBT enrollment form. PIBT enrollment form along with the required documents, if any, must be submitted within 30 days from the event date.

***SPECIAL ENROLLMENT** – Birth and adoption (including placement for adoption) may trigger a special enrollment period during which the employee, spouse, and new dependents can enroll onto the health plan within 30 days of the birth or adoption date. Otherwise, enrollment will need to wait until the next Open Enrollment period.

PIBT will begin billing the first day of the month following any of the lifestyle change/event date, unless the date is 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 is always required.*

CAN HEALTH PLANS BE CHANGED AT ANY TIME?

If an employer offers more than one plan option, and an employee wants to switch to a different health plan, this can only be done during Open Enrollment (December – January). Completed and signed PIBT enrollment forms are required for all plan changes. This rule applies to all medical and ancillary plans.

CAN EMPLOYER PLAN SELECTION INCLUDE DIFFERENT CARRIERS?

Yes, with some exceptions. For example, employers offering a Health Net HMO or EOA plan may not offer any other Health Net ExcelCare or Health Net SmartCare Plan. Employers offering a Blue Shield Access+ HMO plan may not offer any other Blue Shield Local Access+ HMO plan or Blue Shield Trio ACO HMO plan.

HOW DO EMPLOYEE TERMINATIONS GET REPORTED?

It is the employer's responsibility to report all coverage terminations to PIBT within the month in which the employment termination occurred. No retroactive terminations are allowed. This is a change implemented by carriers' requirement. PIBT Employee Termination Notice form must be fully completed and signed by the company's representative; it must include the employee's full name, current home address, and Employee ID number (as shown on your monthly invoice). Please check-off the appropriate box under COBRA or CAL-COBRA coverage qualifying event section. Termination of coverage is effective at the end of the month in which the employment ended. Terminations must be received by the 20th of the month to show on the following PIBT monthly premium invoice.

HOW DOES CANCELLATION OF COVERAGE FOR AN ACTIVE EMPLOYEE AND/OR DEPENDENTS GET REPORTED?

To drop coverage for the employee and/or any covered dependents, employers must fully complete a PIBT Employee Change Notice form and carefully check-off all appropriate boxes under *Drop coverage for*, *Coverage to be dropped,* and *Reason for dropping coverage* sections. Signatures of both, employee and company's representative are required. Coverage cancellation date will always be at the end of the month in which the change was reported to PIBT.

WHAT IF ANY EMPLOYEE DECLINES TO BE COVERED?

Employees and/or any eligible dependents declining coverage must complete a PIBT Declination of Coverage form. Signatures of both, employee and company's representative are required. Eligible dependents can only be enrolled for coverage if the employee is enrolled on the same plan.

IS PIBT MAILING THE REQUIRED NOTICES OF COBRA/CAL-COBRA RIGHTS?

Yes, as an additional service to our participating employers who select PIBT as their COBRA Administrator on their *Member Participation Agreement*, PIBT will mail-out the required notices of COBRA rights (employers with 20 or more employees) or CAL-COBRA rights (employers with 2-19 employees). The COBRA/CAL-COBRA package is triggered once a termination form with a qualifying event is processed. Since the Law requires timely notification, it is critical that terminations be reported within the month in which the employment ended. No retroactive terminations are allowed. This is a change implemented by carriers' requirement. PIBT will coordinate with the COBRA or CAL-COBRA beneficiary directly. Employers will not be responsible for collection of premiums.

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

Remember, death-claims are not automatically paid just because premium payments have been made. Familiarity with the life insurance plan limitations and exclusions is vital. A provision for Waiver of Premiums is available on all life insurance plans offered by PIBT for fully disabled employees who are under the age of 65. This means that, upon approval, coverage is maintained without payment of premiums. Waiver of Premiums claim form, including attending physician statement, must be submitted to the insurance carrier within the specified period. Contact PIBT for details and instructions.

WHERE CAN I OBTAIN PIBT FORMS?

All PIBT forms such as Enrollment, Termination of Coverage, Declination of Coverage, Change of Coverage Notice, Summary of Plan Benefits, Evidence of Coverage, etc., are available on our website **www.pibt.org.**

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

Following is a list of all carriers' member services phone numbers and website links:

MEDICAL	Blue Shield	(888) 235-1765	www.blueshieldca.com
	Health Net	(800) 361-3366	www.healthnet.com
	Kaiser	(800) 464-4000, or (800) 390-3507	www.kp.org
DENTAL	Blue Shield	(800) 585-8111	www.blueshieldca.com
	CIGNA	(800) 367-1037	www.cigna.com
	Western Dental	(800) 992-3366	www.westerndental.com
	Humana Dental	(800) 233-4013, or (877) 873-2241	www.humanadental.com
VISION	VSP	(800) 877-7195	www.vsp.com
	EyeMed	(800) 334-7591	www.eyemedvisioncare.com
CHIROPRACTIC	Landmark	(800) 298-4875	www.LHP-CA.com
MENTAL HEALTH	EAP	(800) 777-9355	www.mhn.com

WHEN ARE PREMIUMS BILLED AND PAYMENT DUE?

Premiums are due on the first of the month. Payment must be received before the end of the 30-day grace period to avoid cancellation of group coverage. If termination occurs, employer will be responsible for payment of any unpaid premiums for the period for which coverage was provided.

Employers may request a review by the California Insurance Commissioner if they believe their coverage or health insurance policy has been or will be wrongly canceled, rescinded or not renewed. To do so, you must submit your request in writing to: California Department of Insurance, Consumer Communications Bureau, 300 S. Spring St., South Tower, Los Angeles, California 90013, or online at www.insurance.ca.gov. You may also call them 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 has been made, unless your policy or coverage is being cancelled for non-payment 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 non-renewal.

<u>WARNING</u>: 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?

Remit your PAYMENTS to the **PIBT lockbox** *(**DO NOT** FEDEX NOR INCLUDE ANY CORRESPONDENCE)*:

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

HOW IS A BILL CONSIDERED PAID BY THE DUE DATE?

PIBT Trustees consider an account paid only when funds are received in PIBT's bank account, at the 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.)

***$150.00 fee will apply if a check is returned for non-sufficient funds.** This fee 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. Once coverage is cancelled, a *Confirmation of Coverage Cancellation 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 the 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 Cancellation notice* is sent. Any monies sent to our lockbox or directed to our office after the *Confirmation of Coverage Cancellation notice* has been mailed, will be promptly refunded. If reinstatement is granted, a $500 reinstatement fee plus all premiums due, including the current month premiums, must be received within 2 business days at the PIBT lockbox *(**DO NOT** FEDEX NOR INCLUDE ANY CORRESPONDENCE)*:

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

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. Because of 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 EMPLOYERS ARE NOT HELD RESPONSIBLE?

It is extremely important to notify PIBT of any coverage changes immediately. This allows PIBT to notify carriers promptly. Unlike commercial insurance carriers who invoice in advance to 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.

WHAT IS THE PIBT PORTAL?

Our secure PIBT website portal gives the PIBT participating employers the ability to have access to your company information 24/7. When registered, employer's health benefits administrators can securely process enrollments, terminations, dependent additions, plan cancellations, view monthly invoices, past payment information and much more. Save time with these available tools and resources. Registering is easy and free! Just contact **OnlineHelpDesk@piasc.org** to get started. If you need assistance or have any questions, please contact Stephanie Hernandez at **(800) 449-4898** extension 259 or **stephanie@piasc.org.**

WHO DO I CALL FOR ADDITIONAL ASSISTANCE?

For assistance 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

Website: **www.pibt.org**

PIBT CUSTOMER SERVICE TEAM

The following list shows your assigned team, their phone extension, e-mail address, and direct fax number.

TEAM LEAD & RELATIONSHIP KEEPER	EXTENSION	COMPANIES BEGINNING WITH THE LETTER:	E-MAIL	FAX NUMBER
ANNA ACUÑA	**240**	**A-Z**	**anna@piasc.org**	**323-215-1798**
Sandra Bonilla	258	A-F	sandra@piasc.org	323-271-0403
Carlos Sanmiguel	226	G-O	carlos@piasc.org	323-271-0136
Denise Holguin	239	P-Z	denise@piasc.org	323-271-0509
LISA VIRGEN	**246**	**MAJOR ACCOUNTS/COBRA**	**lisa@piasc.org**	**323-215-1801**
Jessica Munguia	225	A-Z	jessica@piasc.org	323-303-3173
Stephanie Hernandez	259	PIBT Portal	stephanie@piasc.org	323-271-0138

Our number one goal is to provide 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
Operations Manager
Ph. (323)728-9500 extension 256
E-mail: joanne@piasc.org

You may also contact your Local Association Office:

SOUTHERN CALIFORNIA:

Bob Lindgren
PIASC President
Ph. (323) 728-9500
E-mail: bob@piasc.org

SAN DIEGO:

Karen Fulton
PIASD President
Ph. (858)800-6900
E-mail: karen@piasd.org

NORTHERN CALIFORNIA:

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