

Public Agency & Schools Health Benefits Guide

August 2017

California Public Employees' Retirement System



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Introduction

Introduction The **Public Agency & Schools Health Benefits Guide (Guide)** is designed to assist you, as the employer, in conducting business on behalf of the CalPERS Health Benefits Program which is subject to the Public Employees' Medical & Hospital Care Act (PEMHCA).

You have a fiduciary responsibility to manage the program by ensuring that only eligible employees and their dependents are covered.

This guide aims to increase your knowledge of the health benefits business rules to ensure compliance with federal and state laws and provide you information to assist employees in making informed and educated decisions.

Note: This **Guide** is administrative in nature. In the event of unintentional conflict between the guide and PEMHCA or the Regulations, PEMCHA and the Regulation will prevail.

Important CalPERS Contact Information (for Employers)

CalPERS General

Please contact the CalPERS Customer Contact Center at **888 CalPERS** (or **888-225-7377**) for assistance relating to:

- Resolutions & Compliance
- Enrollment & Eligibility
- Member Appeals
- Billing & Reconciliation
- System Access & Processing
- Other inquiries outside of health, including but not limited to:
 - Service & Disability Retirement
 - Retirement Processing
 - Retirement Checks
 - Survivors & Beneficiaries

Information is also available online at www.calpers.ca.gov.

Circular Letters/Forms & Publications

To request Circular Letters, forms and/or publications, you can:

- Go online to [Circular Letters](#)
- Go online to [Forms & Publications](#)

Circular Letters are mailed and archived online to view and download; all forms and publications are available for download or online order.

Remitting Payment

Check By Mail

California Public Employees' Retirement System - FRAS
Attn: Cashiers
P.O. Box 4032
Sacramento, CA 95812-4032

Check By Overnight Mail

California Public Employees' Retirement System - FRAS
Attn: Cashiers
400 Q Street
Sacramento, CA 95811-6201

By Electronic Funds Transfer (EFT)

For more information on EFT, refer to Course 107 at <https://www.calpers.ca.gov/page/education-center/employer-education/employer-training-classes/mycalpers-student-guides>

Important CalPERS Health Plan Contact Information (for Members & Employers)

Health Plan Resources

Contact the individual health plans for the following items, questions or requests:

- Evidence of Coverage Booklets
 - Identification Cards
 - Verification of Provider Participation
 - Benefits, Deductibles, Limitation & Exclusions
 - Change in Primary Care Provider
 - Service Area Boundaries
 - Individual Conversion Policy
 - Direct Pay or COBRA
-

Anthem Blue Cross	
Customer Service	1-855-839-4524 (HMO) 1-877-737-7776 (PPO) 1-833-848-8730 (Medicare)
Website	www.anthem.com/ca/calpers
Blue Shield	
Customer Service	1-800-334-5847
Website	www.blueshieldca.com/calpers
Pharmacy	https://www.blueshieldca.com/sites/calpersmember/plans-benefits/pharmacy/updates.sp
OptumRX	
Customer Service	1-855-505-8110 (Basic) 1-855-505-8106 (Medicare)
Website	www.optumrx.com/calpers
Health Net	
Customer Service	1-888-926-4921
Website	www.healthnet.com/calpers
Kaiser Permanente	
Customer Service (Basic)	1-800-464-4000 1-800-777-1370 (TTY for the hearing/speech impaired) 1-800-788-0616 (Spanish) 1-800-757-7585 (Chinese dialects)
Customer Service (Medicare)	1-800-443-0815 1-800-777-1370 (TTY for the hearing/speech impaired)
Website	http://my.kp.org/calpers/

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Important CalPERS Health Plan Contact Information (for Members & Employers), Continued

Sharp Health Plan	
Customer Service	1-855-995-5004
Website	https://sharphealthplan.com/calpers/
United Healthcare	
Customer Service	1-877-359-3714 (Basic) 1-888-867-5581 (Medicare)
Website	www.uhc.com/calpers
Western Health Advantage (Effective 1-1-2018)	
Customer Service	1-888-WHA-PERS (1-888-942-7377)
Website	www.westernhealth.com/CalPERS

Important CalPERS Health Plan Contact Information (for Employers Only)

Health Plan Account Management

Below are the CalPERS Account Management Teams for each of our Health Plan Partners. *This information is strictly for employers only.*

Anthem Blue Cross	
Mark R. Johnson Senior Managing Consultant	(916) 638-9586 Office (916) 858-8254 Fax mark.johnson@anthem.com
Wendy Franco Account Manager Consultant	(916) 638-9588 Office (916) 202-1510 Cell (916) 858-8254 Fax wendy.franco@anthem.com
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Kristen Vallone New Agencies, Member/Escalated Member Issues, Enrollment/Benefit/Health Fairs	(916) 329-4452 Office (916) 584-2007 Cell (916) 329-4565 Fax kristen.vallone@blueshieldca.com
Mohammad Suleiman Area Vice President	(415) 229-5848 Office (510) 301-4129 Cell mohammad.suleiman@blueshieldca.com

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Important CalPERS Health Plan Contact Information (for Employers Only), Continued

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Health Net	
Kevin King Senior Account Manager <i>New Agencies, Member Issues</i>	(510) 891-6765 Office (916) 935-4401 Fax kevin.c.king@healthnet.com
Tammy Madsen Major Account Management <i>Plan Design Inquiries, Member Issues, Enrollment Fairs</i>	(916) 935-1325 Office (916) 235-0527 Cell (916) 935-4429 Fax tammy.l.madsen@healthnet.com
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Courtney Tran, Service Manager	courtney.tran@kp.org
Cris Christensen, Territory Manager, NorCAL – Sacramento, Marin, Sonoma, Vacaville	(916) 790-7250 cris.c.christensen@kp.org
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Sunny Smith, Territory Manager, SoCAL – Los Angeles, South Bay and Kern County	(818) 319-0467 sunny.smith@kp.org
Carmen Conover, Territory Manager, SoCAL- Inland Empire (Riverside and San Bernardino)	(909) 371-9914 carmen.x.conover@kp.org
Maria Escalano, Territory Manager, SoCAL – Los Angeles, Orange County and San Diego	(714) 321-4311 maria.c.escalano@kp.org

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Important CalPERS Health Plan Contact Information (for Employers Only), Continued

Sharp Health Plan	
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Important CalPERS Health Plan Contact Information (for Employers Only), Continued

Western Health Advantage (Effective 1-1-2018)	
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Summary of Health Benefit Forms & Publications

Form	CalPERS Form Name	Description
PERS-HBD-12	Health Benefit Plan Enrollment Form	For active employees, to enroll, change, or cancel enrollment in a CalPERS health plan.
HBD-12A	Declaration of Health Coverage	To document an active employee's decision to elect or decline health coverage. Used as proof that coverage was offered.
HBD-30	Health Benefit Plan Enrollment Form for Retirees/Survivors	For retirees or survivors, to enroll, change, or cancel enrollment in a CalPERS health plan.
HBD-34	Medical Report for the CalPERS Disabled Dependent Benefit	For enrollment or continuation of a disabled child over age 26. This form provides medical information to CalPERS and is to be completed by an attending physician.
HBD-98	Member Questionnaire for the CalPERS Disabled Dependent	For enrollment or continuation of a disabled child over age 26. This form provides medical information to CalPERS and is to be completed by the member.
HBD-40	Affidavit of Parent-Child Relationship	To establish eligibility for dependents of a parent-child relationship.
PERS-HBD-85	COBRA Election Form	To continue coverage under COBRA provisions and authorize direct payment for enrollment in a group continuation plan.
PERS-HBD-21	Direct Payment Authorization Form	To apply for continuation of enrollment while employee is on "off-pay" status.
	Health Plan's Evidence of Coverage	A detailed guide describing the benefits of a specific health plan. Also provides the employee with a certificate of coverage. This publication is mailed to new members by the health plan and is also available online through the specific health plan website.

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Summary of Health Benefit Forms & Publications, Continued

Form	CalPERS Publication	Description
HBD-120	Health Program Guide	Provides an overview of the CalPERS Health Program.
HBD-110	Health Benefit Summary	A comprehensive summary of all CalPERS health plans.
HBD-65	CalPERS Medicare Enrollment Guide	A practical guide to understanding how CalPERS and Medicare work together.
	Summary of Benefits and Coverage (SBC) Notice	Provides information to help individuals better understand and compare available health plan options. Employers must provide this notice to newly eligible employees no later than the date they become eligible for health benefits. The SBCs are also available by directly contacting the health plans.

Obtaining Forms

To request forms and/or publications, you can:

- Go online to [Forms & Publications](#)
All forms and publications are available for download or online order
- Contact the CalPERS Customer Contact Center at **888 CalPERS** (or **888-225-7377**)

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Other Forms (CalPERS Members Only)

Personnel Transactions for CalPERS Members

Many of the transactions listed below may be completed online by CalPERS members via my|CalPERS Member Self-Service. Otherwise, please report the following types of personnel transactions on the specified form indicated. The forms listed below pertain to CalPERS members only.

Below are descriptions of the other forms used for CalPERS members

Form	Transaction	Division
BSD-194	Report of Separation and Advance Payroll	Benefit Services
BSD-369-S	Application for Service Retirement	Benefit Services
BSD-369-D	Application for Disability Retirement	Benefit Services
BSD-738	Report of Separation for Death – Request for Payroll Information	Benefit Services
PERS-OSS-138	Special Power of Attorney	Benefit Services

Health Benefit Officer (HBO) - Roles and Responsibilities

Roles and Responsibilities

Employer responsibilities include:

- Providing active and former employees with information about enrollment, benefits, costs, applicable time limits for enrollment, etc.
- Updating my|CalPERS with enrollment changes
- Informing employees that a review of eligibility can occur at any time
- Informing employees of their obligation to advise you if dependents lose eligibility (e.g., divorce)
- Informing the member when an address change is outside their health plan's service area
- Staying up-to-date on communications from CalPERS regarding changes in law or policies
- Updating CalPERS with employer contact information, including HBO and Health PA Billing
- Reviewing the monthly Health Premium Statement and Employer Billing Roster for accuracy
- Maintaining documentation that supports eligibility for enrollment and mandatory changes for member dependents
- Being familiar with the California Public Employees' Retirement Law (PERL) and PEMHCA provisions
 - California Government Codes (G.C.) 20160, 20164, 22750, and 22944.3
 - California Code of Regulations (CCR) 599.500 – 599.517
- Having knowledge of available resources

CalPERS responsibilities include:

- Providing retirees and survivors with information about enrollment, benefits, costs, applicable time limits for enrollment, etc.

This guide is administrative in nature. In the event of unintentional conflict between the guide and the Act or the Regulations, the Act and the Regulations will prevail.

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Health Benefit Officer (HBO) - Roles and Responsibilities,

Continued

Employer Health Contacts

Health Benefit Circular Letters, including Open Enrollment information, are sent to the Health Benefit Officer (HBO) and Health Benefit Assistant (HBA) contacts. Each agency should have at least one HBO and as many HBA's as needed.

Monthly Health Premium Statements are sent to the Health PA Billing contact. Each agency should have one listed.

The [System Access Administrator](#) (SAA) must create and update the contact information as needed. If contact information is invalid, the agency will not receive Health Benefit communications from CalPERS.

Communication

Active employees must make changes through their agency's Health Benefit Officer (HBO) to ensure accurate payroll deductions and employer records. HBO's can also send secure messages using the my|CalPERS "Submit Inquiry" feature.

Retirees and HBOs should contact CalPERS directly at **888 CalPERS** (or **888-225-7377**) for assistance.

If there is a dispute to be resolved and your employee requests a CalPERS review, submit a written request on the employee's behalf. The request must be on agency letterhead, include supporting documents and be signed by an agency personnel specialist or manager.

CalPERS Communication

Introduction

We communicate with you through several communication channels including:

- The CalPERS Website
 - Circular Letters
 - CalPERS Employer Bulletins
 - my|CalPERS
 - Employer News
-

CalPERS Website

The CalPERS website has become an important source of information for you regarding the CalPERS Health Program, such as eligibility rules, covered services, available health plans and premium rates.

Note: For additional information about the [CalPERS Health Program](#), go to the CalPERS website.

Circular Letters

Circular Letters are issued to keep you informed of changes in health policies and procedures. These letters provide important documentation for reference to administer CalPERS benefit programs.

Note: The [Circular Letter Search page](#) located on the CalPERS website can help you find specific topics of interest.

CalPERS Employer Bulletin

Sign up and get the latest employer news and information tailored specifically for you sent right to your email inbox.

CalPERS Employer Bulletins come in plain text format easy for viewing and e-mail retrieval.

Note: Stay informed by signing up for the [CalPERS Employer Bulletin](#) quickly and easily on the CalPERS website.

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CalPERS Communication, Continued

my|CalPERS vs. CalPERS Website

[my|CalPERS](#) is an internet application which provides access to your agency's information and online services. It is your tool for getting things done. **Employers who participate in PEMHCA can access billing rosters, view current and past employer health contributions, and more.**

The [CalPERS website](#), on the other hand, focuses on providing you with information. It is your resource for learning all about CalPERS benefits, programs, and services.

Accessing my|CalPERS

The **CalPERS employer ID** is a 10-digit ID that is assigned to each employer that contracts with CalPERS for benefits.

An organization's my|CalPERS [System Access Administrator \(SAA\)](#) is the key point of contact. For existing organizations, this individual will be accountable for providing my|CalPERS access to any additional contacts (users). This involves utilizing system administrator pages in my|CalPERS to associate predefined access roles to each contact and assign the user a unique username and password.

In addition, this individual will have the responsibility to reset a user's password, lock a user's access rights to the system, and change a user's system access role(s).

Health Plan Options

Health Plan Availability

- Employees are eligible to enroll in a health plan using either their residential or work ZIP Code. The eligibility zip code can be added during the initial enrollment and can only be changed during Open Enrollment or with a qualifying event such as a change of address.
- A P.O. Box may be used for mailing purposes but cannot be used to establish eligibility.
- If a residential ZIP Code is used, all enrolled family members must reside in the health plan's service area.
 - When an enrolled dependent resides separately from your employee, the enrolled dependent's residential ZIP Code must also be included in the health plan's service area.
 - Your employee or enrolled dependent should always contact the health plan to ensure the dependent is assigned to a provider or clinic within the respective health plan's service area.

Example: Your employee lives in Northern California and is enrolled in Kaiser, and their dependent lives in Southern California. They can each seek services as long as both residential ZIP Codes qualify for enrollment.

- If a work ZIP Code is used, all enrolled family members must receive all covered services (except emergency and urgent care) within the health plan's service area, even if they do not reside in that service area.
- A subscriber may choose to use the employer ZIP Code
 - upon initial enrollment
 - during the annual Open Enrollment period
 - upon a move
- Working retirees may use the ZIP Code of their current employer for basic health plan eligibility.
 - If enrolled in a Medicare Advantage plan, the member's residential address must be used.

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Health Plan Options, Continued

CalPERS Health Maintenance Option (HMO) Basic Health Plans

Depending on where your employee resides or works, one or more Basic health plan types and plan choices may be available.

HMO features include:

- A range of health benefits including preventive health services
- A monthly fee (premium) with no calendar year deductible
- A set co-payment for the care provided
- A primary care physician (PCP) who coordinates the patient's care including referrals to specialists

Note: The [California Department of Managed Health Care](#) regulates all HMOs in California. Title 28 Section 1300.51(H) (i) of the California Code of Regulations, defines health plan requirements for the geographic area in which the health plan provides coverage under an HMO.

HMO Basic Health Plans

CalPERS Basic HMO Plans include:

- Anthem Blue Cross
- Blue Shield of California
- Health Net of California
- Kaiser Permanente
- Sharp Health Plan
- UnitedHealthCare
- Western Health Advantage (effective 1-1-2018)
- California Correctional Peace Officers Association (CCPOA)
 - Must belong to the association and be a dues paying member

Note: HMOs are available only in designated California service areas with the exception of Kaiser which is available in parts of other states but the benefits may vary.

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Health Plan Options, Continued

CalPERS Preferred Provider Organization (PPO) Basic Health Plans

Preferred Provider Organization (PPO)

PPO features include:

- Access to a network of health care providers known as preferred providers
- Choice of specialists without a referral
- Option to obtain services from non-preferred providers

Note: A calendar year deductible applies to PPO plans.

PPO Basic Health Plans

PPO Plans include:

- PERSCare
- PERS Choice
- PERS Select
- California Association of Highway Patrolmen (CAHP)*
- Peace Officers Research Association of California (PORAC)*

* Must belong to the association and be a dues paying member.

Note: All of our PPO plans are administered by Anthem Blue Cross and available throughout California. PERSCare, PERS Choice, and PORAC are available in California and throughout the world.

CalPERS Exclusive Provider Organization (EPO) Basic Health Plans

Blue Shield EPO serves Colusa, Mendocino and Sierra Counties only, and Anthem Blue Cross EPO serves Monterey and Del Norte Counties only.

EPO features include:

- Offers the same covered services as an HMO
- Services must be obtained from the statewide EPO network of preferred providers

Note: Evidence of Coverage Booklets can be viewed and/or printed from the applicable health plan website.

Health Eligibility Requirements

Employees

Active employees are eligible to enroll if they have an appointment that is intended to last at least six months and one day (tenure) and half time or greater (time base).

Note: If your agency has adopted the “less than half-time” resolution, then the time base above does not apply and the employee that works less than half time can enroll. Less than half-time employees receive the same employer contribution as their full-time counterparts. Prior to enrollment, the employee must still meet the criteria of tenure (six months and one day or more).

Enrollment must be requested within 60 days from the date of the qualifying appointment, or during any future Open Enrollment or HIPAA special or late enrollment period. The effective date is the first of the month following the date the request is received by the Health Benefits Officer (HBO).

Retirees

Retirees are eligible to enroll if:

- They retire within 120 days of separation, and
- They receive a monthly retirement warrant, and
- They are eligible for health benefits upon separation
- Their former employer still contracts with CalPERS for health benefits for their specific bargaining unit

Enrollment must be requested within 60 days from retirement, or involuntary loss of coverage, or during any future Open Enrollment or HIPAA special or late enrollment period. The effective date is the first of the month following the date the request is received by CalPERS.

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Health Eligibility Requirements, Continued

Family Members/Dependents

Eligible employees may enroll themselves only or themselves and all eligible family members. Below is a list of eligible dependents and the supporting documentation required for enrollment:

Spouse

- Can be added to the health plan within 60 days after the date of marriage or during any Open Enrollment period, involuntary loss of coverage, or HIPAA late enrollment
- Required: Copy of the marriage certificate
- (Copy of the *Divorce Decree* is required to delete a spouse due to divorce)

Domestic Partner

The following are eligible to register for Domestic Partnership with the Secretary of State:

- Specified same-sex domestic partnerships between persons who are both at least 18 years of age
- Specified opposite sex domestic partnerships where one person is over the age of 62
- Can be added to the health plan within 60 days of the registration of domestic partnership or during any Open Enrollment period, involuntary loss of coverage, or HIPAA late enrollment
- Required: Copy of the *Declaration of Domestic Partnership* registered with the Secretary of State
- (Copy of the *Termination of Domestic Partnership* form is required to delete a domestic partner due to dissolution of partnership)

Note: Domestic Partnership Law prohibits a person who has filed a Declaration of Domestic Partnership from filing a new declaration until at least 6 months has elapsed from the date that a Notice Termination of Domestic Partnership was filed with the Secretary of State.

This would be in connection with the termination of the most recent domestic partnership except where the previous domestic partnership ended because one of the partners died or married.

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Health Eligibility Requirements, Continued

Family Members/ Dependents (continued)

Eligible employees may enroll themselves only or themselves and all eligible family members. Below is a list of eligible dependents and the supporting documentation required for enrollment:

Children under age 26

- Either natural-born, adopted, or step (by traditional marriage or domestic partnership)
- Do not need to be enrolled in college or living at home to be eligible
- Required: Copy of birth certificate or adoption papers

Certified “Parent-Child Relationship” Children

- Children of another person, given that a parent-child relationship exists between the employee or annuitant and the child
- Required: [Affidavit of Parent-Child Relationship](#) (Form HBD-40)*
- Required: Specific documents that substantiate their parental role within that PCR
- The subscriber has 60 days from the date the member assumed a primary custodial parental role to request enrollment

Certified Disabled Dependent over age 26

- Who are incapable of self-support because of a mental or physical disability that existed continuously prior to age 26
- Request to continue enrollment must be received 60 days prior to or 60 days after the child’s 26th birthday
- Required: [Member Questionnaire for the Disabled Dependent Benefit](#) (Form HBD-98) and [Medical Report for the CalPERS Disabled Dependent Benefit](#) (Form HBD-34)
- Eligibility determination and enrollments for disabled dependents are processed by CalPERS

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Health Eligibility Requirements, Continued

Eligibility & Supporting Documentation Certified “Parent-Child Relationship”

An employee or annuitant may enroll a child up to the age of 26 (other than an adopted, step or recognized natural child) if the employee or annuitant:

- Has assumed a parental role
- Is considered the primary care “parent”
- Submits a signed [Affidavit of Parent-Child Relationship](#) (HBD-40)
- Submits specific documents that substantiate their parental role within that Parent-Child Relationship (PCR)

Upon enrollment, and annually thereafter the employee must:

- Sign the [Affidavit of Parent-Child Relationship](#) (HBD-40) under penalty of perjury, that the information they are providing is true and correct
- Acknowledge that it is unlawful to make false representation or to present false information

Note: Beginning January 1, 2016, members are now required to fully complete the new HBD-40 Affidavit of Parent-Child Relationship form and submit the required supporting documents for new and recertification requests. Effective May 1, 2017, all subscribers recertifying a PCR dependent under age 19 must submit a copy of the first page of their income tax return from the previous tax year listing the child as a tax dependent. **No exceptions will be allowed.**

Required supporting documentation for a PCR dependent under age 19 includes:

- A copy of the first page of the subscriber’s income tax return from the previous tax year listing the child as a tax dependent.
- In lieu of a tax return, for a time not to exceed one tax filing year, subscribers may submit other documents that substantiate the child’s financial dependency upon them, including the following (collectively referred to as “Other Suitable PCR Documentation”):
 - Current legal judgments or court documents showing the subscriber’s legal parental status or guardianship over the child
 - Bank, credit card, tuition or insurance statements or payments
 - School records
 - Bills or mail indicating common residency with the child

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Health Eligibility Requirements, Continued

Eligibility & Supporting Documentation
Certified
“Parent-Child Relationship”,
Continued

Required supporting documentation for a PCR dependent from age 19 up to age 26 includes:

- A copy of the first page of the subscriber’s income tax return from the previous tax year listing the child as a tax dependent, OR
- Other Suitable PCR Documentation, that substantiates that the child is financially dependent upon the subscriber provided that the child:
 - Either lives with the subscriber for more than 50 percent of the time, or is a full-time student, AND
 - Is dependent upon the subscriber for more than 50 percent of the child’s support.

Requirement Type	Supporting Documentation Age (19-26)
Residency (more than 50% of the time)	<ul style="list-style-type: none"> • School records indicating full-time status, bills or mail in the child’s name listing the same address as the subscriber, such as: <ul style="list-style-type: none"> - School correspondence - Employment correspondence - Bank statements or correspondence - Vehicle registration, insurance bills/statements - Credit card bills/statements - Rental/lease agreements
Financial Dependence (more than 50% of child’s support)	<ul style="list-style-type: none"> • Recurring bills or statements of account, identified as Other Suitable PCR Documentation, paid by the subscriber on behalf of the child, such as: <ul style="list-style-type: none"> - Tuition payments - Cell phone bill payments - Auto loan payments - Auto insurance payments - Credit card payments - Bank statement, custodian account, cancelled checks, or other evidence of financial dependence.

Circular Letter
600-008-15

- [Eligibility Criteria for Dependents in a Parent-Child Relationship](#)
 (Attachment 1: [PCR Regulatory Language](#))
 (Attachment 2: [Affidavit of Parent-Child Relationship](#))
 (Attachment 3: [PCR Subscriber Letter](#))
 (Attachment 4: [Employer FAQs](#))

Continued on next page

Health Eligibility Requirements, Continued

Restrictions The CalPERS Health Program does not permit:

- **Dual Coverage** - Members cannot be enrolled in a CalPERS health plan in their own right (“self”) **and** as a dependent of another member enrolled in a CalPERS health plan. Upon discovery, dual enrollments are cancelled on a retroactive basis, and the health plans will bill the employee for services provided on behalf of ineligible family members.
 - **Split Enrollments** - If two parents are enrolled in a CalPERS health plan, each in their own right, all child dependents must be enrolled on a single CalPERS health plan. You cannot split these dependents among the two different CalPERS health plans.
-

Exclusions Family member exclusions are allowed on a voluntary basis when a family member is:

- Covered under another group health plan
- A spouse not living in the employee’s household
- A child over 18; or
- In the military service

These family members may be added at a later time during the Open Enrollment period or due to HIPAA.

Ineligible

- Children age 26 and over
- Children’s spouses
- Disabled children over age 26, who were never enrolled or were deleted from coverage
- Former spouses
- Stepchildren of former spouses or domestic partners*
- Parents
- Grandparents
- Parent in-laws
- Other relatives*

***Note:** The child may be enrolled as a dependent in a Parent-Child Relationship if such relationship exists and can be substantiated.

Continued on next page

Health Eligibility Requirements, Continued

Notification of Deletion of 26 Year Old Dependents

Four months prior to the dependent's 26th birthday, CalPERS will mail a notice to the employee advising that the child dependent is reaching age 26. The notice provides:

- Current enrollment data
- Dependent deletion information
- Referral to the employer for Certified Disabled Dependent or COBRA information and documents

CalPERS will notify the health plan. The employer should download the Employer Health Event Transaction report in my|CalPERS which will show the 26 year old deletion transaction.

Note: If you have a new employee who adds a 25 year old child, the automatic deletion system may not work if the enrollment is not on our system prior to the three month lead time. Contact CalPERS at **888 CalPERS** (or **888-225-7377**) if you are in doubt about the deletion system time frame.

Important: Please report address changes immediately. This will ensure notifications about coverage and COBRA are sent timely and to the correct location.

Effective Date

Health coverage will **terminate on the last day of the month** in which the dependent attains age 26.

Continued on next page

Health Eligibility Requirements, Continued

Continuation of Coverage as Certified Disabled Dependent

The deletion of a 26-year-old dependent is mandatory unless incapable of self-support because of a physical or mental disability. If the 26-year-old qualifies as a Certified Disabled Dependent, the dependent is eligible for continued coverage. Please refer to the *Certified Disabled Dependent* section of this guide for further information.

Continuation of Benefits

Overage dependents are eligible to continue their coverage through the federal COBRA provision. The agency is responsible for offering the COBRA continuation coverage under the federal guidelines. Please refer to the *COBRA* section of this guide for further information.

Circular Letter 600-043-10

[Extension of Dependent Coverage Up To The Age of 26](#)

(Attachment A: [Active Subscriber](#))

(Attachment B: [Retiree Subscriber](#))

(Attachment C: [Age Outs](#))

(Attachment D: [COBRA Subscriber](#))

Continued on next page

Health Eligibility Requirements, Continued

Enrollment - Certified Disabled Dependents

The coverage of a Certified Disabled Dependent may only be established under the following conditions:

- Upon the initial enrollment of the employee,* or
- As a continuation of coverage beyond age 26

*Upon initial enrollment, please complete two HBD-12s:

- One for the employee and any other eligible family members
 - One for the disabled dependent
 - In the **REMARKS** box, indicate *“Coverage of disabled dependent (name) is contingent upon approval by CalPERS.”*
-

Eligibility & Supporting Documentation

The enrollment of a Certified Disabled Dependent is subject to CalPERS approval.

The following documentation must be submitted to CalPERS to determine eligibility:

- [Member Questionnaire for the CalPERS Disabled Dependent Health Benefit](#) (Form HBD-98)*
- [Medical Report for the CalPERS Disabled Dependent Benefit](#) (Form HBD-34)*

Important: The Medical Report form must be completed by the child’s physician, who must mail the form to CalPERS directly for processing. The Medical Report must be received by CalPERS within 60 days following the initial enrollment or 60 days prior to or 60 days after the child’s 26th birthday.

Continued on next page

Health Eligibility Requirements, Continued

Deletion - Certified Disabled Dependents

If the disabled dependent is later deemed ineligible for health benefits, the child will be deleted on a retroactive basis and the employee will be responsible for any medical services rendered.

If the coverage of the 26 year old dependent is deleted in error prior to the eligibility certification as a disabled child, the coverage may be reinstated, providing CalPERS has received the medical information within 60 days following the 26th birthday. Coverage will be continuous without lapse.

Exclusions

The following disabled children are **excluded** from coverage:

- Dependent children whose disability occurred after age 26
 - Dependents who initially continued coverage as disabled dependents beyond age 26 under the PEMHCA program and who were later deleted from the enrollment
 - Dependents who are capable of self-support
 - Disabled dependents whose coverage (extension) was not requested in a timely manner
-

School Employers: 10-Month Work Schedule

10 Month Work Schedule

Schools may have employees who work 10 months a year but are entitled to 12 months of health coverage.

- CalPERS will continue to bill on a monthly basis for 12 months in a calendar year
 - The school employer should collect an extra portion of the premium each month for 10 months so they have the amount needed to pay for the premium during the two months the employee is not receiving a check
-

Termination

If the employee terminates employment, **coverage will end the first of the second month following the last day on payroll.**

If you have collected premiums for the additional two months, you can **refund** the premiums to the member or work with the member to **pay for their first two months of COBRA** premiums.

Separation

When a member separates to retire, **coverage will end the first of the second month following the last day on payroll.** Once the member's retirement date is confirmed, coverage is, in many cases, reinstated automatically. In the cases where it is not, coverage may be able to be reinstated manually. Please contact the CalPERS Customer Contact Center at **888 CalPERS** (or **888-225-7377**) for assistance.

The employee will be moved from the active billing to the retired billing the first of the second month following the last day on payroll.

If you have collected premiums for the additional two months, you should **refund** the premiums so the member can pay their share of the premiums as a retiree. The billing system will recognize the retirement and charge only the employer share on the monthly invoice. The balance will be taken from the member's retirement warrant.

Summary of Benefits and Coverage & Uniform Glossary

Purpose The Affordable Care Act (ACA) requires health plans and other responsible parties to make available a Summary of Benefits and Coverage (SBC) and a uniform glossary of common health insurance terms. Together, these documents provide important information to help individuals better understand their health benefit coverage and more easily compare health plan options.

Newly Eligible Employees The SBC implementing regulations require responsible parties to provide SBC and glossary information to newly eligible employees no later than the first date on which they are eligible to enroll in coverage.

To meet the SBC and glossary notification requirements, employers must insert their school/agency letterhead at the top of the [Summary of Benefits and Coverage Notice](#) (or create their own) and include it in their hiring or benefits package.

Current Members CalPERS and its health plans currently notify existing members of how to access and obtain copies of these documents during Open Enrollment.

Penalties Failure to provide SBC and uniform glossary information, as described in the regulations, could yield penalties of up to \$1,000 for each failure.

Additional Information Circular Letter [600-051-15](#).

Health Enrollment

HBD-12

Active Employees

Electing, changing, or cancelling coverage

The [Health Benefit Plan Enrollment Form \(HBD-12\)](#) and [Instructions](#):

- Is the document used to report all enrollment transactions for active employees
- Must be submitted within 60 days of the date of a qualifying appointment/event
- Should be copied for the agency's file and for the employee
- Is used for **single transactions** with few exceptions. When multiple transactions are necessary, have employee submit as a package, stapled together.
- Includes a **REMARKS** box for explanations that resulted in the submission of the document

HBOs are responsible for the accuracy of all enrollment documents.

Continued on next page

HBD-12A

Active Employees

Electing or declining coverage

The [Declaration of Health Coverage \(HBD-12A\)](#):

- Is the document used to report that an active employee elects or declines to enroll in a health plan
- Verifies that the employee was given the opportunity to enroll and has voluntarily elected or declined the benefit
- If this form cannot be produced when employee claims they were never offered health insurance, then the employee must be offered health insurance effective the first of the month following date of request

If an employee elects no coverage within the 60 day time limit, a subsequent enrollment can only be requested upon:

- HIPAA's special or late enrollment period
- Open Enrollment
- Involuntary loss of coverage
- Loss of coverage for any reason where the employee is a dependent of another CalPERS member (CCR 599.502 f (4))

Continued on next page

Health Enrollment, Continued

HBD-12A

Active Employees

Electing or declining coverage Continued

An employee who elects no coverage and subsequently retires will be eligible for coverage as an annuitant as long as they meet the following criteria:

- Retires within 120 days of separation
 - Receives a monthly allowance through CalPERS or another retirement system
 - They are eligible for health benefits upon separation
 - Their former employer still contracts with CalPERS for health benefits for their specific bargaining unit
 - Enrolls within 60 days of retirement; or enrolls during any future Open Enrollment period, HIPAA late enrollment, or involuntary loss of coverage
-

HBD-30

Retirees & Survivors

Electing, changing, or cancelling coverage

The [Health Benefit Plan Enrollment Form for Retirees/Survivors \(HBD-30\)](#):

- Is the document used to report all enrollment transactions for retirees or survivors
- Must be submitted within 60 days of the date of a qualifying appointment/event
- Provided to CalPERS by the retiree or survivor

If a retiree or survivor elects no coverage within the 60 day time limit, a subsequent enrollment can only be requested upon:

- HIPAA's special or late enrollment period
- Open Enrollment
- Involuntary loss of coverage
- Loss of coverage for any reason where the annuitant is dependent of another CalPERS member (CCR 599.502 f (4))

Note: Retirees or survivors enrolling in a CalPERS *Supplement to Medicare* or *Managed Medicare* plan must provide a copy of the Medicare card for each Medicare eligible enrollee (subscriber and/or dependent).

Continued on next page

Health Enrollment, Continued

Live/Work Rule

The availability of health plans to a member is determined by their eligibility ZIP code.

- Active employees can use either their residential ZIP code or their employer's ZIP code to qualify for a health plan (only upon initial enrollment or Open Enrollment)
 - Retirees can use either their residential ZIP code or their employer's ZIP code to qualify for a health plan as long as they are enrolled in a non-Medicare Advantage plan. A "working" retiree in a Medicare Advantage plan must use their residential ZIP code to determine health plan eligibility.
 - P.O. Boxes cannot be used to determine eligibility
-

Medical Identification Cards

Members should receive their medical identification cards (ID cards) within 2-3 weeks after submission of the enrollment or after the health coverage effective date. Members can go online and access Member Self-Service to confirm enrollment.

If not, the HBO should confirm the transaction. If the transaction is confirmed, the employee should contact the health plan directly to inquire about their ID card(s).

Changes

Demographic changes or corrections

- Active employees and their dependents – HBO can key directly into my|CalPERS
- Retirees and their dependents – Contact the CalPERS Customer Contact Center at **888 CalPERS** (or **888-225-7377**)

Changes to health plan and/or dependents

- Active employees need to submit an [HBD-12](#) and [HBD-12A](#) to their HBO during Open Enrollment or special enrollment period or qualifying event
- Retirees need to contact CalPERS or they can make most changes online using my|CalPERS Member Self-Service

Changes to primary care physicians or medical group

- Members should contact the health plan directly
-

Continued on next page

Health Enrollment, Continued

Communication

All mail concerning the CalPERS Health Program should be directed to the following:

Enrollment forms, related documents and correspondence:
CalPERS Member Account Management Division
P. O. Box 942714
Sacramento, CA 94229-2714

Note: *If using FedEx or UPS for mailing purposes:*
CalPERS Member Account Management Division
400 Q Street, Second Floor LPN
Sacramento, CA 95811

For remittance of billing invoice payment and coupon:
California Public Employees' Retirement System
P. O. Box 4032
Sacramento, CA 94812-4032

Specific Provider Needs

If a specific doctor, medical group or hospital is preferred, a health plan must be selected which allows access to the specific provider. Each enrollee should contact the health plan(s) and/or provider directly to inquire about the availability of the specific provider **before** enrolling.

IMPORTANT: When employees enroll in a health plan, services are provided through the health plan's delivery system and the continued participation of any one doctor, hospital, or other provider **cannot be guaranteed**. The provider network may change during the plan year. Employees may be permitted to select another provider but not another plan. If the health plan is unable to offer a satisfactory "Physician/Patient" relationship with the enrollee for reasons such as a limited provider network in a particular area, the enrollee may contact CalPERS Health Plan Administration Division in writing to request a health plan change through the appeal process.

Special Medical Needs

Health plan benefit designs are not identical. Current or anticipated medical needs must be considered in choosing a plan in order to minimize out-of-pocket expenses and fulfill individual needs. Individual *Evidence of Coverage* booklets are available from each health plan which explain benefits, limitations and exclusions.

Continued on next page

Health Enrollment, Continued

Out of Pocket Expenses The out-of-pocket expenses vary greatly between the plans. In addition to the monthly premium (if any employee share applies), there may be deductibles and co-payments to meet. Not all plans require such deductibles and co-payments. [The Health Benefit Summary](#) publication (HBD-110) provides more information on these expenses.

Evidence of Coverage The EOC provides detailed information about the benefits, limitations and exclusions of the health plan.

EOCs are sent to all new enrollees and are also available:

- By returning the publication request postcard sent during Open Enrollment
 - For download or order online at www.calpers.ca.gov
 - By contacting the health plan directly
-

Member Claims and Appeals Any disputes about medical benefits, coverage or claims should be resolved through the health plan. This includes requests for a change in primary care provider, the referral process, and clarification about co-payments. If the health plan denies a benefit that is listed in the EOC booklet, the enrollee should follow the grievance procedure outlined in the EOC. If that is not successful, the employee may then contact CalPERS Health Plan Administration Division at **888 CalPERS** (or **888-225-7377**) or in writing for assistance.

IMPORTANT: CalPERS can only provide assistance if the enrollee has made every reasonable effort to resolve the dispute with the health plan **first** and is requesting a benefit that is listed in the EOC booklet. Requests for “additional” benefits which are not listed in the EOC booklet or requests by the enrollee for plan changes because a particular provider is no longer available **cannot** be resolved by the claims assistance officer. Government Regulation Code: 599.518

Circular Letter 600-060-10 [Collecting and Maintaining Dependent Social Security Numbers](#)

Retroactive Reimbursement

Retroactive Transactions

Retroactive transactions occur when the eligibility status for a member or dependent changes due to death, marital status, changes in employment and other circumstances, and the **change is not reported in a timely manner**.

These transactions often result in a difference between the premiums *paid* and the premiums that *should have been paid* if the transaction had been properly reported.

Reimbursement

Reimbursement to members and employers is limited to the amount of excess health premiums paid for a period of **up to six months** prior to the date on which the action is processed and recorded, pursuant to the member's request for retroactive cancellation or deletion of the ineligible family member.

Please note that if the enrollment is updated on a prospective basis, there may be no refund of health premiums given.

Responsible Parties

Timely notification requires a collaborative effort between employers, members and CalPERS. When enrolling in the CalPERS health care program, members certify that all dependents are eligible family members. Employers are responsible for accurately reporting changes from members to CalPERS, as well as advising CalPERS of employment changes to covered members. CalPERS is responsible for confirming updated information so that health plans are providing services to eligible members only.

Members who fail to report an enrollment change could be liable for retroactive reimbursement to their employer of premiums in **excess of six months** prior to the date on which the action is processed and recorded.

Employers who do not record the transaction are only entitled to retroactive benefit premiums **up to six months** from the date the deletion or cancellation is processed and recorded.

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Retroactive Reimbursement, Continued

Example 1

The following is an example of a retroactive reimbursement claim caused by failure of a **member** to appropriately report a mandatory deletion or cancellation:

An employee gets a divorce, on December 12, 2013; however, the employee does not report the divorce until December 6, 2016. This is a *mandatory* deletion with an effective date of January 1, 2014. If the employee had reported the divorce in a timely manner, the former spouse's coverage would have been cancelled, and he/she would have received COBRA group continuation information.

Since the member reported the event late, this creates a retroactive health benefit premium overpayment for 36 months (January 2014 – December 2016). The reimbursement of excess premiums will be calculated for only the last six months (July 2016 – December 2016), and the health plan may bill the member for any claims submitted for the former spouse subsequent to January 1, 2014.

Example 2

The following is an example of a retroactive reimbursement claim caused by failure of an employer to appropriately report a mandatory deletion or cancellation:

An employee separates from employment on January 5, 2014; however, the employer does not report the separation until December 6, 2016. This is a *mandatory* cancellation with an effective date of March 1, 2014. If the employer had reported the separation in a timely manner, the former employee's coverage would have been cancelled, and he/she would have received COBRA group continuation information.

Since the employer reported the event late this creates a retroactive health benefit premium overpayment for 34 months (March 2014 – December 2016). The reimbursement of excess premiums will be calculated for only the last six months (July 2016 – December 2016), and the health plan may bill the member for any claims submitted subsequent to March 1, 2014.

Circular Letter
600-215-05

[Limiting Retroactive Reimbursement Liability for Health Premiums](#)
(Attachment: [FAQ's for Employers](#))

Health Enrollment Reason Codes

Reason Codes Guide

Use the following guide as a tool when preparing an HBD-12 enrollment form or entering a transaction in my|CalPERS. The guide should be referenced on a consistent basis to ensure that the appropriate code and effective date is applied.

Note: Reason Codes replaced Permitting Event Codes and will be entered in box 14 of the HBD-12 health benefit plan enrollment form. See the [my|CalPERS Health Aid](#) for more information.

Using the Guide

The reason codes are grouped into sections such as new enrollments, adding or deleting dependents, changing plans and cancellation.

Important: When adding or deleting dependents, make note if the event is *mandatory* or *permissive*. This will affect effective dates and COBRA rights.

Mandatory Transactions (M)

Additions to or deletions from health enrollments **due to requirement by law**. Events such as divorce, death of a dependent, overage 26 year old dependents, spouse/dependent enrolling in a CalPERS health plan in their own right, and birth of a newborn, are all mandatory transactions.

The effective date is the first of the month following the event date.

Permissive Transactions (P)

Additions to or deletions from health enrollments **due to voluntary request** of the member and not required by law. Events such as a dependent who moves out of the household, obtains other non-CalPERS health coverage, or enters military service, as well as a change in child custody or addition of a new spouse or stepchild, are all permissive transactions.

The effective date is the first of the month following the HBO received date.

Continued on next page

Reason Codes Guide**

NEW ENROLLMENT			
Reason Code	Description	Event Date	Effective Date Method
100	New Qualifying Appointment	Date of Appointment	2
101	Loss of Health Coverage	Date other coverage ends	2
102	New Enrollment after Reinstatement from Retirement	Date of Appointment	2
103	Return from Military Leave	Date employee returns to work	2
104	New Enrollment for Employee during <i>Open Enrollment</i>	First date of Open Enrollment	4
105*	New Enrollment for Retiree during <i>Open Enrollment</i>	First date of Open Enrollment	4
108	Employee enrolling in their own CalPERS health plan after deletion as a dependent from a CalPERS health plan	Date dependent coverage terminates	2
109*	Retiree enrolling in their own CalPERS health plan after deletion as a dependent from a CalPERS health plan	Date dependent coverage terminates	2
111	New Enrollment for Employee off pay status during Open Enrollment Period	Date of return to pay status	6
112*	New Retirement Enrollment	Date of Retirement	3
113*	Deferred Retirement Enrollment	Date of Retirement	3
119	Pending Retirement	Date of Separation	7
123	Enroll Direct Pay	Equal to the date of the layoff	7
129	Special Enrollment Employees	Date determined by CalPERS	5
131	COBRA - Reduction in Hours	Date hours reduced	7
132	COBRA - Loss of Employment	Date employment terminates	7
133	COBRA - Div/Sep/Move from Household	Date of divorce, separation or move form household	1(M)
134	COBRA - Death of Employee	Date of Death	1(M)
135	COBRA - Dep Cont-Subscriber on Medicare	Date of subscribers 65 th birthday	1(M)
136	COBRA - Loss of Dependent Status	Date dependent loses dependent status	1(M)
146	Re-enroll SES/PA FFPO Survivor	Date of Death	3
148	Enroll less than half-time employee	Date of Appointment	2
160	Return from off pay status	Date of return to pay status	1(M)
163	New contracting survivor without benefits	Date of new contract	8
167	Re-employment	Equal to the date of the appointment	2
169	Pending Retirement – Deferred Retirees (Internal Use Only)	Date of Separation	7
170	OE Enroll < half time Employee New Enrollment	First date of Open Enrollment	4

Continued on next page

Reason Codes Guide, Continued

NEW ENROLLMENT FOR NEW CONTRACTING AGENCIES			
Reason Code	Description	Event Date	Effective Date Method
115	New enrollment for Employee of Newly Contracting PA	Date of Contract	8
116*	New enrollment for Retiree of Newly Contracting PA	Date of Contract	8
117*	New enrollment for Survivor of Newly Contracting PA	Date of Contract	8
118*	New enrollment for Leave Of Absence (LOA) of Newly Contracting PA	Date of Contract	8
139	COBRA - New Contract Agency Subscriber	Date of new contract	8
140	COBRA - New Contract Agency Dependent	Date of new contract	8
150	New enrollment for Less Than Half-time Employee of Newly Contracting PA	Date of Contract	8
218	New Contracting – Medically Disabled	Date of new Contract	8

ADDING DEPENDENTS			
Reason Code	Description	Event Date	Effective Date Method
200	Adding Newborn or Newly Adopted Child	Date of birth, date of adoption or placement for adoption	1(M)
201	Adding New Spouse or Step-children due to Marriage	Date of Marriage	2
202	Adding child due to Change in Custody	Date dependent is acquired	2
203	Adding “miscellaneous” child who lives in parent-child relationship with employee	Date dependent is acquired	2
204	Adding dependent due to loss of non-CalPERS health coverage	Date other coverage terminates	2
205	Adding dependent due to return from Military Leave	Date of return from Military leave	2
206	Adding dependent during Open Enrollment	First date of Open Enrollment	4
207	Adding dependent upon return from off pay status during Open Enrollment	Date of return to pay status	6
208	Adding dependent due to Court Order	Date of Court Order	1(M)
213	Special Enrollment Dependent	Date determined by CalPERS	5
215	Adding Domestic Partner	Date of Domestic Partner Registration	2
216	Adding Domestic Partner Children	Date of Domestic Partner Registration or date dependent is acquired	2

Continued on next page

Reason Codes Guide, Continued

DELETING DEPENDENTS			
Reason Code	Description	Event Date	Effective Date Method
300	Deleting dependent due to Death	Date of death	1(M)
301	Deleting dependent who reaches Age 26	Dependent's 26 th birth date	1(M)
302	Deleting dependent(s) due to Divorce	Date of divorce	1(M)
303	Deleting child due to Marriage	Date of child's marriage	1(M)
304	Deleting dependent who is enrolling in their own CalPERS health plan	The day before the effective date	1(M)
305	Deleting dependent who is no longer Disabled	Date determined no longer disabled	1(M)
306	Deleting ineligible dependent	Date determined ineligible as a dependent	1(M)
307	Deleting dependent who obtains other coverage	Date other coverage begins	1(P)
308	Deleting dependent due to Legal Separation	Date of legal separation	1(P)
309	Deleting dependent who goes on Military leave	Date of military leave	1(P)
310	Deleting dependent due to loss of eligibility as "miscellaneous" child	Date dependent loses eligibility	1(M)
311	Deleting all dependents	Date of request	1(P)
312	Deleting dependent due to Change in Custody	Date custody changes	1(P)
313	Deleting dependent who moves out of household	Date of move	1(P)
318	Deleting Domestic Partner	Date Domestic Partnership terminates	1(M)
319	Deleting Domestic Partner children	Date Domestic Partnership terminates	1(M)
320	Deleting dependent during Open Enrollment	First date of Open Enrollment	4
324	Deleting 26 year old	Date of dependent's 26 th birth date	1(M)

ELIGIBILITY ZIP CHANGE			
Reason Code	Description	Event Date	Effective Date Method
480	Add Eligibility ZIP Code	Administratively determined	3
481	Terminate Eligibility ZIP Code	Admin. Determined	3

Continued on next page

Reason Codes Guide, Continued

CHANGING HEALTH PLANS			
Reason Code	Description	Event Date	Effective Date Method
400	Open Enrollment Change in Health Plans	First date of Open Enrollment	4
401	Changing health plans upon return from off pay status during Open Enrollment	Date of return to pay status	6
402	Change in physical address (Move)	Date of move	1(P)
403	Gain Association Membership	Date of membership	1(P)
404	Lose Association Membership	Date loses membership	1(M)
405*	Special Open Enrollment	Administratively determined	3

DIRECT PAY			
Reason Code	Description	Event Date	Effective Date Method
704	LOA	Date of last day on pay status	7
705	Workers' Comp/Claim Pending	Date of claim pending	7
712	Change to deduction – return to work	Date of return to work	1(M)
713	Change to deduction other	Date of event	1(M)
714	Change to Direct Pay Other	Date of event	1(M)
715	Change to deduction – FMLA	Date of event	1(M)
716	Change to deduction – Retirement	Date of event	1(M)

CANCEL			
Reason Code	Description	Event Date	Effective Date Method
501	Change in Appointment to Non-Participating Bargaining Unit	Date of change in appointment	1(M)
502	Employment status changes to non-qualifying	Date status changes	7
504*	Delay in Retirement Roll Placement	Administratively determined	1
505	Voluntary Request to Cancel Coverage	Date of Request	1(P)
507	Appeal Denied	Date of Appeal Denied	1(M)
515	Cancel: Permanent Separation	Date of Permanent Separation	7
516	Layoff cancel	Date of Layoff	7
526	Subscriber Death	Date of Death	1(M)
530	Cancel coverage during Open Enrollment	First date of Open Enrollment	4
532	Survivor dependent no longer eligible	Date determined ineligible as a dependent	1(M)
533	Off Pay Status – Cancel Coverage	Date of Off Pay Status	7
534	Military Leave	Date of Military Leave	1(P)
535	Reinstatement (Non-PERS)	Date of Reinstatement	1(M)
536	Subscriber Request - COBRA	Date of Request	2

Continued on next page

Reason Codes Guide, Continued

COVERAGE CHANGE			
Reason Code	Description	Event Date	Effective Date Method
709	Insufficient Earnings	Date of Insufficient Earnings	7
710	Pending NDI	Date Participant goes on NDI	7
904	Change Medical Group	User Defined	1(M)
908	Opt in Vesting	Date of Request	2
909	Opt out Vesting	Date of Request	2

*Processed by CalPERS

EFFECTIVE DATE KEY	
Effective Date Method	Effective Date Description
1	1 st day of the month following the Event Date (Mandatory Event) or HBO Received Date (Permissive).
2	1 st day of the month following the HBO Received Date if within 60 days of the Event Date. If HBO Received Date is beyond the 60 th day, the effective date is the 1 st day of the month following a 90 day waiting period from the HBO Received Date (Permissive Event).
3	Administratively determined.
4	Open Enrollment effective date (January 1 of contract year).
5	Special Open Enrollment effective date determined by CalPERS. HBO Received Date must be within special enrollment dates established by CalPERS.
6	1 st day of the month following HBO Received Date or most recent Open Enrollment effective date, whichever is latest.
7	1 st day of the 2 nd month following the Event Date.
8	1 st day of the month following HBO Received Date if within 60 days of the Contract Date. If HBO Received Date is beyond the 60 th day, the effective date is the 1 st day of the month following a 90 day waiting period from the HBO Received Date (Permissive Event).

****Note:** When processing health transactions in my|CalPERS, you will use Health Event Reasons in lieu of the Reason Codes. For more information, see the online [my|CalPERS Health Aid](#).

NEW my|CalPERS HEALTH EVENT REASONS

The new my|CalPERS will change the way that you process health transactions for your agency.

The health event reasons used today will still exist when the new my|CalPERS goes live. In addition to those, there will be approximately 35 new health event reasons from which to choose for my|CalPERS system users, both internal CalPERS staff and external CalPERS employers.

Please review the following list of the new Health Event Reasons created for external CalPERS employers to use.

NEW HEALTH ENROLLMENT REASONS

New Contracting Survivor without Benefits

Use this reason to enroll Public Agency survivors who, by agency resolution, continue health coverage but receive no survivor benefit.

Re-Employment

Use this reason when the reason for enrollment is re-employment.

Pending Retirement-Deferred Retirees

Use this reason to enroll members who are in a deferred status. This new health event type is used to reflect continued enrollment, rather than new enrollment.

Open Enrollment Enroll Half-Time Employee New Enrollment

Use this reason to enroll Public Agency half-time employees during Open Enrollment.

HEALTH PLAN CHANGES REASONS

Change Plan Due to Eligibility ZIP Change

Use this reason when a request to change health plan accompanies a change-in-eligibility ZIP code.

HEALTH PLAN CANCELLATION REASONS

Military Leave

Use this reason to cancel coverage if the member goes on military leave and opts not to continue health coverage.

Continued on next page

NEW my|CaIPERS HEALTH EVENT REASONS, Continued

Reinstatement (Non-PERS)

Use this reason to cancel a Non-PERS Public Agency retiree who reinstates their employment.

Subscriber Request-COBRA

Use this reason when the subscriber requests cancellation of COBRA coverage.

UPDATES TO DEPENDENT ADDRESS, MISC. ENROLLMENT, DEPENDENT RECERTIFICATION REASONS

Address Update

Use this reason when a dependent address is updated.

Change Medical Group

Use this reason to continue health coverage for Public Agency enrollees when there is a change of qualifying medical groups.

Update Demographics

Use this reason to continue health coverage when there is a change to the demographic information for the subscriber or dependent.

Opt In Vesting

Use this reason when a Public Agency member, who is not required to opt in based on hire date or Memorandum of Understanding effective date, elects to opt in to the vesting provision as part of the health contract.

Opt Out Vesting

Use this reason when a Public Agency member, who previously opted into the vesting provision but was not required to opt in based on hire date or Memorandum of Understanding effective date, now elects to opt out of the provision.

Health Insurance Portability & Accountability Act (HIPAA)

Implementation In 1996, Congress enacted the Health Insurance Portability and Accountability Act (HIPAA). This section's focus of HIPAA is on the portability of health insurance. The requirements of HIPAA took effect January 1, 1998 and changed enrollment practices and policies for employees and family members eligible to enroll in a CalPERS health plan.

Implications These changes did not eliminate or alter current enrollment rules and procedures with the exception of the elimination of the Health Statement, which was replaced with "**Special Enrollment**" and "**Late Enrollment**" periods. These enrollment periods allow employees and their dependents specific opportunities to enroll in the CalPERS Health Program.

In all instances, the employee and dependent must be eligible for enrollment in a CalPERS-sponsored health plan as defined by Part 5, The Public Employees' Medical and Hospital Care Act (PEMHCA).

Declaration of Health Coverage (HBD-12A) The [Declaration of Health Coverage](#) (HBD-12A) form provides information on enrollment options and consequences for non-enrollment. Beginning January 1, 1998, each employee **must** sign the HBD-12A when they are **first eligible** to enroll or when they make **any change** to their health coverage. This includes Open Enrollment changes, changing health plans when moving, adding or deleting a dependent, or canceling health benefits. You must provide the HBD-12A at the time the employee requests enrollment or with the Health Benefit Plan Enrollment (HBD-12) form. You also must provide the employee a copy of the signed form and keep the original in the employee's file.

Continued on next page

HIPAA, Continued

Special Enrollment

The employee may request **enrollment for self or self and all eligible family members**. The request must include proof of loss of other coverage and be received within 60 days after the other coverage ends. The effective date is the first of the month following the request to enroll.

A. Enrollment Decisions After January 1, 1998

On or after January 1, 1998, employees who were not provided written notice by the employer of the consequences of **declining or cancelling** coverage are eligible to enroll. The effective date of enrollment is the first of the month following receipt of the request to enroll.

B. Loss of Other Coverage

If an employee **declines or cancels** enrollment for self or dependents because of other coverage (employer sponsored or other insurance coverage), they can enroll when the other coverage is no longer available. Involuntary loss of other coverage is defined as:

- Termination of employment of the individual through whom the employee or dependent was covered
- Termination of the other plan's coverage
- COBRA continuation coverage has been exhausted
- Cessation of employer's contribution toward employee or dependent coverage, or
- Death, divorce, or legal separation of a person through whom the employee or dependent was covered

C. Non-Enrolled Employee Acquiring a Dependent or Enrolled Employee's Non-Enrolled Spouse

If an employee **declines or cancels** enrollment or an **enrolled employee declines or cancels enrollment for spouse** and later acquires a dependent as a result of marriage, birth, adoption, or placement for adoption, they can enroll self or self and all newly eligible dependents. The request must be received within 60 days of acquiring the dependent. The effective date is:

Continued on next page

HIPAA, Continued

Special Enrollment (continued)

- Marriage, the first of the month following request to enroll
- Birth, the first of the month following request to enroll
- Adoption or placement for adoption, the first of the month following request to enroll

The employee may request **enrollment for self or self and all eligible family members**. The request must include proof of loss of other coverage and be received within 60 days after the other coverage ends. The effective date is the first of the month following the request to enroll.

D. Court-Ordered Coverage

1. **Child of an enrolled employee:** A court has ordered coverage be provided for a child under an **enrolled** employee's health plan. If the employee's current health plan has a restricted geographical service area and is not available in the child's residential area, the employee must change to a health plan that will cover the child. If the employee refuses to change health plans, the **employer must** enroll the employee and dependent child in PERS Choice. The effective date is the first of the month following the court order date (unless the court order specifies a specific effective date of coverage).
2. **Child of a non-enrolled employee:** A court has ordered coverage be provided for a child under a **non-enrolled** employee's health plan. The employee can enroll in a health plan available in the child's residential area. If the employee refuses to enroll, the **employer must enroll** the employee and child in PERS Choice. The effective date is the first of the month following the court order date (unless the court order specifies a specific effective date of coverage).
3. **Spouse of an enrolled employee:** A court has ordered that coverage be provided for a spouse under an **enrolled** employee's health plan. If the employee's current health plan has a restricted geographical service area and the health plan is not available in the spouse's residential area, the employee must change to a health plan that will cover the spouse. The effective date is the first of the month following the court order date (unless the court order specifies a specific effective date of coverage).

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HIPAA, Continued

Late Enrollment Employees who **decline or cancel** enrollment for self or dependents (including spouse) and who do not qualify for a “Special Enrollment” may enroll during Open Enrollment or at **any time** may request enrollment as a **Late Enrollee**. Employees who request **Late Enrollment** for self or dependents must normally wait a minimum of 90 days before they are enrolled in a CalPERS-sponsored health plan. The effective date is the first of the month following the 90 day waiting period or the Open Enrollment effective date, whichever comes first.

Certification of Group Health Plan Coverage HIPAA requires that employees and their dependents receive a *Certification of Group Health Plan Coverage* when health coverage terminates. Health plans contracting with CalPERS will be responsible for providing a *Certification of Group Health Plan Coverage* when enrollees, or dependents who were covered under the plan, lose coverage. The *Certification of Group Health Plan Coverage* will be mailed to the enrollee’s last known address and will be provided when:

- An individual ceases to be covered under the plan and has a right to elect COBRA continuation coverage;
- An individual ceases to be covered under the COBRA continuation provisions; or
- A request is made by an individual not later than 24 months after the date of cessation of coverage.

CalPERS is committed to providing timely and accurate information. Implementation of HIPAA is an evolving process and may be amended with further clarification issued by federal regulators. If you have any questions in regard to this material, contact the CalPERS Customer Contact Center at **888 CalPERS** (or **888-225-7377**).

HIPAA Reason Codes Guide

SPECIAL ENROLLMENT – ENROLLMENT DECISIONS AFTER 1/1/98

The employer cannot produce an HBD-12A for an eligible but *non*-enrolled employee or a *non*-enrolled dependent of an enrolled employee. **Note: Applies to employees who declined or canceled enrollment or deleted a dependent on or after January 01, 1998. THIS SECTION DOES NOT APPLY TO RETIREES.**

Description	Reason Code	Event Date	Time Limit of Request	Effective Date	Instructions
Employee enrolling new. Note: Employer cannot produce HBD-12A for employee eligible 1/1/98 or later.	100 (enrolling new)	Date employee requests enrollment	Anytime	1 st of the month following receipt of HBD-12 in the employing office	Remarks: HIPAA No Doc. (HBD-12A)
Enrolled employee adding dependent(s). Note: Employer cannot produce HBD-12A for dependents eligible 1/1/98 or later.	201 (adding dependents)	Date employee requests enrollment	Anytime	1 st of the month following receipt of HBD-12 in the employing office	Remarks: HIPAA No Doc. (HBD-12A)

SPECIAL ENROLLMENT – LOSS OF OTHER COVERAGE

An eligible *non*-enrolled employee/retiree or eligible *non*-enrolled dependent(s) of an enrolled employee/retiree may enroll when they lose other health insurance coverage. Employee/retiree provides proof of loss of other coverage and employee/retiree requests to enroll within 60 days of the date of loss of other coverage.

Description	Reason Code	Event Date	Time Limit of Request	Effective Date	Instructions
Eligible employee/retiree enrolling new for self or for self and all eligible dependents that lose other coverage.	101 (enrolling new)	Date employee loses other coverage	60 days from the loss of coverage	1 st of the month following receipt of HBD-12 in the employing office or retiree notification to CalPERS	Remarks: HIPAA Loss of Other Coverage
Enrolled employee/retiree adding <i>non</i>-enrolled dependent(s) that lose other coverage.	204 (adding dependents)	Date dependent loses other coverage	60 days from the loss of coverage	1 st of the month following receipt of HBD-12 in the employing office or retiree notification to CalPERS	Remarks: HIPAA S/E Loss of Other Coverage

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HIPAA Reason Codes Guide, Continued

SPECIAL ENROLLMENT – NON-ENROLLED EMPLOYEE/RETIREE ACQUIRING A DEPENDENT OR ENROLLED EMPLOYEE/RETIREE'S NON-ENROLLED SPOUSE

An eligible *non*-enrolled employee/retiree may enroll if the employee/retiree acquires a new dependent by marriage, birth, adoption or placement for adoption. Employee/retiree can enroll self or self and all eligible dependents.

An enrolled employee/retiree may enroll a *non*-enrolled spouse when the employee/retiree acquires a dependent by birth, adoption or placement for adoption. Employee/retiree can enroll spouse, newly acquired dependent(s), and all other eligible dependent(s).

Time limit is 60 days from the event date to request enrollment (except for newborns or newly adopted children).

Description	Reason Code	Event Date	Time Limit of Request	Effective Date	Instructions
Eligible <i>non</i>-enrolled employee/retiree enrolling new for self only or for self and all eligible dependent(s) due to newly acquired dependent(s) by marriage, birth, adoption or placement for adoption.	100 (enrolling new)	Date employee/retiree acquires dependent by marriage, birth, adoption/ placement for adoption	60 days from the date employee/retiree acquires dependent	1 st of the month following receipt of HBD-12 in the employing office or retiree notification to CalPERS	Remarks: HIPAA S/E Non-enrolled employee/retiree acquiring a dependent
Enrolled employee/retiree adding non-enrolled eligible dependent(s) (spouse/child(ren)) due to newly acquired dependent by birth, adoption or placement for adoption.	201 (adding spouse and/or dependents)	Date employee/retiree acquires dependent by birth, adoption, or placement for adoption	60 days from the date employee/retiree acquires dependent	1 st of the month following submission of HBD-12 to employer or retiree notification to CalPERS Note: Newborns and newly adopted child(ren) are effective the 1 st of the month following date of event	Remarks: HIPAA Enrolled employee/retiree acquiring a dependent

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HIPAA Reason Codes Guide, Continued

SPECIAL ENROLLMENT – COURT ORDERED COVERAGE					
<p>Dependent (spouse/child) of an eligible but non-enrolled employee/retiree: Court orders coverage for the dependent of an eligible but non-enrolled employee/retiree. The employee/retiree must enroll in a plan that is available in the dependent's area. The employer or CalPERS must enroll the employee/retiree and the dependent in PERS Choice if the employee/retiree refuses enrollment.</p>					
<p>Dependent (spouse/child) of an enrolled employee/retiree: Court orders coverage for a dependent of an enrolled employee/retiree. If the employee/retiree is enrolled in a geographically restricted plan, which is not available in the dependent's service area, the employee/retiree must change to a plan that will cover the dependent. The employer or CalPERS must change the employee's plan to PERS Choice if the employee/retiree refuses to change plans.</p>					
Description	Reason Code	Event Date	Time Limit of Request	Effective Date	Instructions
Court orders coverage for a dependent (spouse/child) of an eligible but <i>non</i> -enrolled employee. Employee/retiree must enroll in a plan that will cover the dependent.	100 (employee/retiree enrolling new)	Date the court order is received by employer or CalPERS	Anytime	1 st of the month following receipt of court order in employing office or CalPERS	Remarks: Court Ordered Coverage
Court orders coverage for a dependent (spouse/child) of an enrolled employee/retiree. Employee/retiree must change to a plan that is available in the dependent's area.	208 (adding spouse or child)	Date court order is received by employer or CalPERS	Anytime	1 st of the month following receipt of court order in employing office or CalPERS	Remarks: Court Ordered Coverage
Court orders coverage for a dependent (spouse/child) of an enrolled employee/retiree. Employee/retiree must change to a plan available in the spouse's or child's area.	410 (changing plans)	Date court order is received by employer or CalPERS	Anytime	1 st of the month following receipt of court order in employing office or CalPERS	Remarks: HIPAA Court ordered coverage Note: Provide dependent's ZIP code

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HIPAA Reason Codes Guide, Continued

LATE ENROLLMENT					
<p>An eligible employee/retiree can request “late” enrollment for self and/or his/her dependent(s) at any time if the employee/retiree or dependents do not qualify for a <i>Special Enrollment</i> or any other enrollment provided by PEMHCA. The late enrollee must wait 90 days from the date the request to enroll was received by the employer or by CalPERS. The effective date is the first of the month following the 90-day waiting period.</p> <p>Note: Request for late enrollment during the Open Enrollment period will be effective the first of the month following the 90-day waiting period or the Open Enrollment effective date, whichever is earliest.</p>					
Description	Reason Code	Event Date	Time Limit of Request	Effective Date	Instructions
<p>Employee/retiree, who declined or cancelled enrollment, is enrolling new. Employee/retiree does not qualify for <i>Special</i> or PEMHCA enrollment</p>	<p>100 (enrolling new)</p>	<p>Date of employee's initial eligibility</p>	<p>Anytime</p>	<p>1st of the month following 90-day waiting period</p>	<p>Remarks: HIPAA Late Enrollment</p>
<p>Employee/retiree, who declined or cancelled enrollment of dependents, is enrolling dependents. Dependents do not qualify for <i>Special</i> or PEMHCA enrollment.</p>	<p>201 (adding dependents)</p>	<p>Date of dependents' initial eligibility</p>	<p>Anytime</p>	<p>1st of the month following 90-day waiting period</p>	<p>Remarks: HIPAA Late enrollment</p>

Direct Payment Authorization Continuing Coverage while on “Off-Pay” Status

Direct Payment

An employee who is not on regular pay status for a full pay period or more may elect to either cancel their health benefits coverage or **continue coverage** by paying the premium directly to the health plan (Direct Payment).

The employee’s pay status must be updated **prior** to processing an employee’s health benefits election (cancel coverage or Direct Payment).

HBD-21

To elect Direct Payment, an employee must complete a [Direct Payment Authorization Form](#) (HBD-21) within 30 days of his or her last day on pay status.

The employer must process the HBD-21 information in my|CalPERS. The health plan will then bill the employee directly on a monthly basis. The employee must send payments directly to the health plan.

- Remittance address will be provided on the bill
 - Checks payable to the health plan
 - Failure to submit the payment timely may result in cancellation or a lapse in coverage
-

“Off-pay” Pending Disability Retirement

Direct payment may be made by any enrolled employee when the employee is in an “off-pay” status and is awaiting approval for a disability retirement.

Any enrollee in this situation is in a state of limbo, having been separated but not yet a retiree. The member’s situation may remain unresolved for a lengthy period of time. To ensure continuation of services and prompt payment of claims while a disability retirement is pending, prepare an HBD-21 for the employee’s signature within thirty (30) days of their last day on pay status.

If disability retirement is approved:

Then the member is placed on the retirement roll and CalPERS will verify payments made to the health plan by the member. If payments were made, the agency will be billed for the employer share of the premiums paid by the member. The health plan will then refund the member.

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Direct Payment Authorization, Continued

Continuing Coverage while on “Off-Pay” Status

**“Off-pay”
Pending
Disability
Retirement**
(continued)

If disability retirement is denied:

Then the member who has been paying directly to the health plan will be entitled to group coverage until the last day of the month in which the denial is issued. If the member becomes ineligible as a result of a denial for disability retirement, the member will be entitled to COBRA.

**“Off-pay”
Other Reason**

Direct payment may be made by any enrolled employee when the employee is in an “off-pay” status of over 30 days such as a leave of absence, pending worker’s compensation/claim, suspension, FMLA, or termination due to lay-off.

Note: An employee terminated due to lay-off may elect to use Direct Payment for up to one year or continue coverage for up to 36 months under the provisions of the Consolidated Omnibus Budget Reconciliation Act (COBRA). If the employee elects Direct Payment, they may forfeit their COBRA rights, as COBRA must be elected within 60 days of COBRA notification.

**Adding or
Deleting
Dependents**

While on Direct Payment, the employee may add or delete dependents. Open Enrollment plan changes are allowed during the annual Open Enrollment period while on “off-pay” status, or the employee may defer changing plans within 60 days after returning to regular pay status.

COBRA

Please refer to the *COBRA* section of this guide for further information.

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Direct Payment Authorization, Continued

How to Complete the HBD-21

Part A **ITEMS 1-4:** Complete with the appropriate employee information.

Part B **ITEMS 5-6a:** Enter name, address, plan code and gross premium of the carrier.

ITEMS 6b-6c: Enter the ALPHABETICAL month and NUMERICAL year to which the first direct pay premium is to be applied.

ITEMS 6d-6e: Employee must sign and date the form.

Part C **ITEMS 7-14:** Check reason for the direct payment authorization. If Box #14 is checked, an explanation must be entered.

Part D **ITEMS 15a-15b:** Enter agency name and employee position information.

ITEM 16: Enter the NUMERICAL beginning and ending dates that must correspond with the dates reflected on the employment history database. If the ending date is not available, such as for reasons 8, 13 and 14, allow one full year for direct pay.

Example: Employee applies for disability retirement and is separated on 10/15/00, which is the “from” date in box 16. The employer pays the November 2000 premium out of the October 2000 pay period. The employee starts the direct pay beginning with the December 2000 premium, and it may continue through November 30, 2001 which is the “to” date. The coverage may be extended after November 2001 if the disability retirement is still pending at that time.

Note: If the direct pay dates are extended, a new HBD-21 is required.

ITEM 17: Enter the ALPHABETICAL month and NUMERICAL year of the last pay period from which a payroll deduction was taken.

Note: If the employee enters non-pay status April 10, April should be entered in Item 17, and June in Part B, Item 6b. The appropriate year must also be entered. Deductions from the April pay period pay the May premium.

ITEMS 18-20: Health Benefits Officer or Assistant must complete and sign.

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Direct Payment Authorization, Continued

Cancelling Coverage while on “Off-Pay” Status

Cancellation An employee who is not on regular pay status for a full pay period or more may elect to either **cancel their health benefits coverage** or continue coverage by paying the premium directly to the health plan (Direct Payment).

The employee’s pay status (appointment) must be updated in my|CalPERS **prior** to processing an employee’s health benefits election (cancel coverage or Direct Payment).

HBD-12 and HBD-12A If opting to cancel coverage, an employee must complete and submit the HBD-12 and HBD-12A forms (to be retained in the employee’s file) to their employer no later than the last day of the month following the month in which the last payroll deduction was taken. Once the appointment has been updated, the health benefits cancellation can be processed. A cancellation, off pay status must be processed no later than the 20th of the month following the last month on pay status. **Note:** If the leave type is an “Unpaid Leave” or “Other Leave,” the system will automatically cancel the health benefits and the employer will no longer be billed for the employee’s premiums.

Example:

Change in pay status (leave of absence)

1. Employee will be going on “off-pay” status on March 15.
 2. Employer adds an appointment event (Begin Leave) in my|CalPERS to reflect the employee’s leave of absence. A leave type of “Unpaid Leave” or “Other Leave” will automatically cancel the employee’s health. *March pay period pays the April premium; therefore, April is the last month of coverage.*
 3. Employee submits to the employer the HBD-12 and HBD-12A electing to cancel coverage before they go on leave.
 4. For all leave types other than an “Unpaid Leave” or “Other Leave,” the employer would process a “Cancel Coverage” health event type with a “Off Pay Status Cancel” health event reason in my|CalPERS.
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Direct Payment Authorization, Continued

Cancelling Coverage while on “Off-Pay” Status

Resuming Coverage

If the employee elects to resume health coverage upon return to active pay status, another HBD-12 and HBD-12A must be completed and retained in the employee’s file. The new enrollment must reflect the same health plan and dependents covered prior to the change in pay status, subject to eligibility factors. After my|CalPERS reflects the appointment with the return to pay status, my|CalPERS must then be updated with a new enrollment, *Return from Off Pay Status* during the month the employee returns to pay status to ensure proper health premium payment.

Example:

Change in pay status (return to work from an unpaid leave)

1. Employee returns to work on June 15.
2. Employer adds an appointment event (End Leave) in my|CalPERS to reflect the employee’s return to work. An “End Leave” will not automatically re-enroll an employee for health benefits.
3. Employee submits to the employer the HBD-12 and HBD-12A by June 30 electing to re-enroll in health coverage.
4. Employer processes a “New Enrollment” health event type and a “Return from Off Pay Status” health event reason in my|CalPERS.

Timely completion and processing of the cancellation and resumption of coverage is necessary to avoid premium discrepancies and retroactive adjustments. If the employee does not elect to resume coverage upon the return to active pay status a request for reenrollment will only be allowed during a future Open Enrollment period under the provisions of the Health Insurance Portability and Accountability Act (HIPAA).

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Direct Payment Authorization, Continued

How to Complete the HBD-12

**“Off-Pay”
Status**

ITEMS 1-4: Employee must complete with appropriate information.

**Cancel Health
Coverage**

ITEM 14: Enter **Event Code 533**.

ITEM 15: Enter date employee goes off pay status.

ITEM 16: Enter second month following the event date.

ITEMS 20-21: Employee must sign and date the form.

ITEMS 28-34: Enter agency specific information.

ITEM 35: Enter “EE elects to cancel coverage while off pay status.”

The Health Benefits Officer or Assistant must sign the HBD-12 and retain it in the employee’s file.

COBRA/Cal-COBRA (Group Continuation)

COBRA Consolidated Omnibus Budget Reconciliation Act (COBRA) is a federally mandated program which requires continuation of health coverage when an event occurs that normally would have terminated coverage for an employee or dependent. This section is intended to provide basic information regarding COBRA. It is general in nature and not designed to render legal advice.

Generally, the employer must provide employees with COBRA rights within 45 days of separation from employment, or for dependents losing coverage, within 45 days of notification of dependent's ineligibility for coverage.

It is each employer's responsibility to meet the requirements of the law. For notice requirements, or if legal or other expert assistance is required, the services of a competent professional should be sought.

Forms [COBRA Election Form](#) (PERS-HBD-85)
[COBRA Election Form – Retirees Only](#) (HBD-85R)

Applicability COBRA allows the employee or dependent to continue identical health coverage, regardless of pre-existing conditions.

COBRA is mandated by the federal government for employers with 20 or more employees.

Benefits & Rates COBRA enrollees' coverage (medical benefits, deductibles and co-payments) is **identical** to regular coverage under the Public Employees' Medical and Hospital Care Act (PEMHCA). COBRA enrollees retain all benefits under their previous coverage, including Open Enrollment plan changes, addition of family members, etc.

The monthly premium under COBRA is normally **102%** of the current health plan rate. CalPERS sends out the new contract year COBRA rates with annual Open Enrollment information.

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COBRA/Cal-COBRA (Group Continuation), Continued

Payment As an employer under PEMHCA, the agency does not collect premiums from the COBRA enrollee or maintain any record keeping for the health plans. Once the COBRA form is completed, the COBRA enrollee interacts **directly with the health plan carrier**, unless the enrollee has future changes, e.g., changing plans, adding or deleting dependents, etc.

Coverage is continuous, so **payment for premiums must be made from the date coverage is lost**. Therefore, timely distribution of COBRA election materials is critical.

Month Events **An employee and/or dependents** may enroll in federal COBRA coverage for the following events:

- Separation from employment (except for “gross misconduct”)
- Resignation resulting in loss of coverage
- Involuntary termination resulting in loss of coverage
- Reduction in time base that causes a loss of coverage

Under COBRA, continuation coverage for the above events would end after 18 months. **Cal-COBRA provides an additional 18 months** of coverage for these events. However, the monthly premium for the additional 18 months is **110%** of the health plan rate. (Up to **150%** can be charged for disabled individuals.)

Events pertaining to employees apply to all “qualified beneficiaries.” A qualified beneficiary is anyone who is covered on the plan on the day prior to the COBRA event. Each qualified beneficiary has separate election rights under COBRA and may choose their own health plan.

Month Events **Dependents** may enroll in COBRA for the following events:

- Divorce
 - Legal separation or spouse moves out of household
 - Death of an employee/annuitant that causes a covered spouse or dependent child to lose coverage
 - Survivor is pending determination for survivor benefits due to the “Pre-Retirement Death” of member
 - Employee becomes eligible for Medicare and the Medicare entitlement causes covered dependent(s) (spouse or child) to lose coverage
 - Dependent child ceases to be a dependent
 - Dependent child reaches age 26
 - Children of '57 and '59 Survivors reach age 18 and 22 respectively
-

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COBRA/Cal-COBRA (Group Continuation), Continued

Secondary Events **An extension of the 18 month continuation period can occur, if during the 18 months of continuation coverage, a second event takes place.**

Second events include:

- Divorce
- Legal separation
- Death
- Medicare coverage
- Dependent child ceasing to be a dependent

The original 18 months of continuation would be extended to 36 months from the date of the original qualifying event for the qualified beneficiary spouse and/or dependent children. Since this “second event” is mandated by COBRA, the additional 18 months will be at **102%** of the health plan premium. It is the responsibility of the qualified beneficiaries to notify the employer or CalPERS of the second event within 60 days of the event. Coverage cannot extend beyond 36 months from the original COBRA event.

Disabled Enrollees The determination of a disabled individual (employee or dependent) must be made by the Social Security Administration. The plan administrator (former employer) must be informed within 60 days following the determination but prior to the end of the original 18 month enrollment. Individuals who become disabled within the first 60 days of COBRA may qualify for an **additional 11 months** of COBRA coverage up to a total of 29 months. The premium is **150%** of the applicable group rate for the additional 11 months (months 19-29). Generally, Medicare begins in the 30th month and COBRA will end. However, if there is a need for coverage to be extended further, Cal-COBRA would provide **seven additional months** of coverage for a total of 36 months.

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COBRA/Cal-COBRA (Group Continuation), Continued

Termination of COBRA Coverage

The following events will **terminate** COBRA coverage:

- Termination of employer contracted health benefits coverage
- Failure to pay the premium in a timely manner
- Subscriber becomes entitled to Medicare coverage (but coverage for dependents may continue)
- Coverage as an employee under another group health plan, except if the other plan excludes a pre-existing condition which the COBRA coverage does not
- The expiration of the applicable coverage period

Upon involuntary expiration of the COBRA coverage, the enrollee may apply for a conversion policy.

Individual Conversion Policy

An individual conversion policy is an alternative to COBRA, or it can follow COBRA coverage. If an employee loses their CalPERS health benefits or COBRA coverage, they can request an individual conversion policy through their prior health plan, which is then underwritten by the plan. Individuals must request this new policy within 30 days of losing coverage. All CalPERS health plans offer this individual conversion policy option. The cost and benefits will differ from the cost of your previous coverage.

COBRA Provisions for New Contracting Agencies

A qualified beneficiary already participating in COBRA through the agency's old plan may, if old plan is terminated, **finish the COBRA period in a PEMHCA plan.**

Some newly contracting agencies have agreements to continue children on plan after age 26. These children will be set up in our COBRA plan for a period of 36 months from the date of the agency contract with CalPERS health. Dependents can choose any plan within his/her residential ZIP code area.

Employee Separations

Reporting

Reporting

Employers must update the appointment status of their employees in my|CalPERS.

Always report the separation date.

Accurate reporting of employee separations will ensure correct billing on a monthly basis. Transactions that update the member's enrollment status with the health plan, update the billing as well. During these status changes, timely* and accurate information will ensure a smooth transition for your employee and his/her dependents. The agency's responsibility in each type of separation is listed below.

***Recent amendments to the California Code of Regulations (CCR), sections 599.502(f) (2) and 599.506(c) (1), limit the liability of health plans to reimbursement of premiums to six months. Please see the *Retroactive Reimbursements* section of this guide for more information.**

Employee Resignations

Effective Date

Termination of the health insurance coverage as an active employee is the first day of the second month following the last day on payroll. Since this is prepaid health coverage and payroll deductions are taken the month preceding the coverage month, the employee is entitled to coverage for the month following the dismissal or resignation date (CCR 599.506).

COBRA

Provide employee with COBRA election forms. Please see the *COBRA* section of this guide for more information.

Cancelling Coverage

If the employee does NOT want the coverage for the month following his/her separation, the employee must sign an HBD-12 electing to voluntarily cancel his/her coverage. If the employee cancels coverage, he/she will NOT be eligible for group continuation benefits (COBRA).

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Employee Separations, Continued

Leave of Absence

Continuing or Cancelling Coverage while on Leave of Absence

An employee who is not on regular pay status for a full pay period or more may elect to either cancel their health benefits coverage or continue coverage by paying the premium directly to the health plan (Direct Payment). The effective date is the last day of the second month following the Begin Leave date. Please refer to *Direct Payment Authorization* section of this guide for more information.

Death of Employee

Effective Date

The effective date of the termination of the health insurance coverage is the first day of the month following the date of death. Provide dependents, if any, with COBRA election forms. Please see the *COBRA* section of this guide for more information.

Eligible Survivors of Deceased Active Employees

If your agency has filed a resolution electing participation under section 22819, complete an HBD-12 to enroll the eligible surviving family members.

Special provision for Survivors of Police and Firefighters

If the employee died as a result of injury or disease out of, and in the course of his or her official duties, section 22820 will apply. Contact **888 CalPERS** (or **888-225-7377**) for more information.

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Employee Separations, Continued

Separation for Service Retirement

Reporting

- Employees must apply for Service Retirement from their respective retirement systems
 - PERS members must file a BSD-369-S ([Application for Service Retirement](#)) which can be done online through my|CalPERS member self-service. If at all possible, the employee should submit this form to PERS at least 90-days prior to retirement date
- Employers must update the appointment status (permanent separation) for their employees in my|CalPERS
- Please see the *Health into Retirement* section in this guide for more information.

Effective Date

Termination of the health insurance coverage as an active employee is the first day of the second month following the last day on payroll. After a permanent separation is entered, the system will use the previous day to derive the effective date for health into retirement. Our office will continue billing as an active employee until then.

Direct Pay

While it is not necessary to submit a [Direct Payment Authorization](#) (HBD-21) form when an application for service retirement is being processed, it may be done if a delay in receiving retirement benefits is anticipated. Please refer to the *Direct Payment Authorization* section of this guide for a more information.

After the permanent separation is processed, process a new enrollment “pending retirement” in my|CalPERS.

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Employee Separations, Continued

Separation for Disability Retirement

Reporting

- Employees must apply for disability retirement from their respective retirement systems
 - PERS members must file a BSD-369-D ([Application for Disability Retirement](#))
- Employers must update the appointment status for their employees in my|CalPERS
- For PERS members, employers also submit a BSD-194 ([Report of Separation and Advance Payroll Information](#))

Effective Date

Termination of the health insurance coverage as an active employee is the first day of the second month following the last day on payroll. Our office will continue billing as an active employee until then.

Continuing Coverage (Direct Pay)

Applications for disability retirement can take a long time to process (months), resulting in a delay of retirement benefits. It is strongly recommended that employees submit an HBD-21 when a disability retirement is pending. Otherwise, the member will **not be covered** until the retirement account is established. If the member requires health services during this time, they will be denied. Please refer to the *Direct Payment Authorization* section of this guide for more information.

Health Benefits into Retirement

Eligibility

To be eligible for health coverage in retirement, the following conditions must be met:

- Person must retire within 120 days from date of separation
- Person must receive a monthly retirement allowance from CalPERS, CalSTRS, or other retirement system*
- Person must have been eligible for enrollment on date of separation
- Agency remains contracted with CalPERS for health benefits for their specific bargaining unit

***Note:** Retirees who elect a lump sum payment are not eligible for health benefits.

Health into Retirement CalPERS & CalSTRS

The employer must change the employee's appointment status to "**Permanent Separation**" in my|CalPERS. The permanent separation will cancel the health.

Do **not** process a *New Enrollment – Retirement* transaction, as:

What will happen	
If person retires within 30 days of separation...	Continuation into health is automatic. CalPERS will also send the retiree a letter asking for Medicare information if it is needed.
If person retires after 30 days of separation...	He/she will be terminated from coverage and must call CalPERS directly to re-enroll into health.
If the person retires after 120 days of separation...	He/she is no longer eligible to participate in CalPERS health benefits.

Note: For STRS employees, employers can update the appointment in my|CalPERS or via file upload, depending on how the agency submits enrollment changes.

Note: If the person is NOT enrolled in health as an active employee but wants health in retirement, he/she must contact CalPERS to enroll into health as a retiree.

Retirees (or survivors) can request enrollment within 60 days of notification of their eligibility for health benefits. If they miss this window, they must wait for the next Open Enrollment period, loss of coverage or HIPAA event.

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Health Benefits into Retirement, Continued

Health into Retirement Non-CalPERS

The employer must change the employee's appointment status to "**Permanent Separation**" in my|CalPERS. Do not cancel health itself, as the separation will cancel health.

What will happen	
If person retires within 120 days of separation...	<p>He/she is eligible to participate in CalPERS health benefits as a retiree.</p> <p>There is no automatic continuation into health. Employers can set up the participant's retiree health by processing a <i>New Enrollment – Retirement</i> transaction in my CalPERS.</p> <ul style="list-style-type: none"> • <i>Health Event Type: New Enrollment</i> • <i>Health Event Reason: Retirement</i> • <i>Health Event Date: The month prior to the effective date</i>
If the person retires after 120 days of separation...	He/she is no longer eligible to participate in CalPERS health benefits.

Billing of Retiree Share

- For PERS members, CalPERS will set up warrant deductions for the retiree share of the health premium
- For STRS members, CalPERS will contact STRS to set up warrant deductions for the retiree share of the health premium
- For Other Non-PERS members, CalPERS will continue to bill the employer for the full premium. Employers must set up a payment system between the Non-PERS retiree and the agency for the retiree's share.

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Health Benefits into Retirement, Continued

**CalPERS as
HBO**

Remind employees that CalPERS becomes the HBO for retirees and to direct retirees to the CalPERS Customer Contact Center if they have enrollment changes or questions about their CalPERS Health Benefits.

**Circular
Letters**

For more information on permanent separation dates, please refer to Circular Letters [200-070-11](#), [200-002-13](#) and [200-015-16](#).

Medicare

Medicare

Medicare is a federal health insurance program for individuals:

- Age 65 or older
- Under age 65 with certain disabilities
- With End-Stage Renal Disease (ESRD)

The [Social Security Administration](#) (SSA) is the federal agency responsible for Medicare eligibility determination, enrollment, and premiums. For more information contact the SSA at (800)772-1213 or TTY (800) 325-0778, or visit their website at www.ssa.gov.

The [Centers for Medicare & Medicaid Services](#) (CMS) regulates the Medicare program. For more information contact CMS at (800) 633-4227 or TTY (877) 486-2048, or visit their website at www.cms.gov.

Medicare Enrollment

Turning Age 65

Four months prior to the active or retired member's and/or dependent(s) 65th birth month, they will receive notification from CalPERS of the requirements to continue CalPERS health coverage after turning age 65. The notification includes:

- Ineligibility of Medicare Certification form
- Medicare Plan Options

When a member is actively employed past age 65 and their health coverage is based on this employment, they will remain enrolled in a CalPERS basic health plan.

- An active member and/or dependent who is working past the age of 65 may defer Medicare enrollment through the SSA if they are covered under an active employer group health plan (EGHP).
- An active member and/or dependent may enroll in Medicare; however the basic health plan is the primary payer while the member is actively working and covered by an EGHP.
- When a member is retired and is turning age 65, the member and/or dependent turning age 65 must enroll in Medicare if they are Medicare eligible or provide supporting documentation from the SSA that they are ineligible for Medicare. This action must be taken prior to their 65th birthday or their CalPERS health coverage will be cancelled.

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Medicare, Continued

Medicare Enrollment

Under Age 65

If you are under the age of 65 and Medicare eligible you must provide your Medicare Part A and Part B information to CalPERS by submitting a copy of your Medicare card and then transfer to a CalPERS Medicare health plan. Your enrollment into a CalPERS Medicare health plan will be processed and effective upon approval by the CMS.

For more information regarding CalPERS Medicare health plans please visit our website at www.calpers.ca.gov.

Survivor Benefits (Special Legislation)

**STRS
Survivors
without an
Allowance**

GC 22760(i)

Effective January 1, 2001, Assembly Bill 2383 established an annuitant category for survivors of CalSTRS retirees left without an allowance. Please refer to Government Code 22760(i), which state the conditions for such survivors to be eligible for CalPERS health coverage.

- (1) A family member of a deceased retired member of CalSTRS, if the deceased member meets the following conditions:*
- (A) Retired within 120 days of separation from employment; and*
 - (B) Retired before the member's school employer elected to contract for health benefit coverage under PEMHCA, and*
 - (C) Prior to death received a retiree allowance from STRS, but did not provide for a survivor allowance to family members.*

In the instance of a school employer that newly elects coverage under PEMHCA, the family member must elect coverage as an annuitant within one calendar year from the date that the school employer elected health benefit coverage through PEMHCA.

These survivors are deemed annuitants and have a mandatory right to enroll by law. Survivors are entitled to the employer contribution the employer provides other retirees of the same bargaining group.

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Survivor Benefits (Special Legislation), Continued

Survivors of Active Employees

GC 22819

Government Code 22819 allows survivors of active employees to be eligible for CalPERS health coverage. The survivors of the active employee would be made an eligible annuitant on the date of the active employee's death.

Employers must file a separate resolution electing this provision.

- (a) A family member of a deceased employee of a contracting agency who is validly enrolled or is eligible for enrollment hereunder on the date of the employee's death is deemed to be an annuitant under Section 22760, pursuant to regulations prescribed by the board.*
- (b) A contracting agency shall remit the amounts required under Section 22901 as well as the total amount of the premium required from the employer and enrollees hereunder in accordance with regulations of the board. Enrollment of the annuitant and eligible family members shall be continuous following the death of the employee, or the effective date of enrollment, so long as the surviving family members meet the eligibility requirements of Section 22775 and regulations pertinent thereto. Failure to timely pay the required premiums and costs or the cancellation of coverage by the annuitant shall terminate coverage without the option to reenroll. The contracting agency may elect to require the family members to pay all or any part of the employer premium for enrollment.*
- (c) This section shall apply to a contracting agency only upon the filing with the board of a resolution of its governing board electing to be subject to this section.*

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Survivor Benefits (Special Legislation), Continued

**Survivors of
Other
Annuitants
without an
Allowance**

Effective January 1, 2011, Government Code 22819.1 allows for other survivors without an allowance to be eligible for CalPERS health coverage.

Employers must file a separate resolution electing this provision.

GC 22819.1

(a) A family member of a deceased annuitant who retired from a contracting agency prior to the effective date of the agency's contract to provide health coverage under this part, and who was validly enrolled in the agency's health plan on the day prior to the effective date of the contract under this part, but who does not receive an allowance in place of the annuitant, is deemed to be an annuitant for purposes of Section 22760, pursuant to regulations prescribed by the board.

(b) A contracting agency shall remit the amounts required under Section 22901 as well as the total amount of the premium required from the employer and enrollees in accordance with regulations of the board. Enrollment of the eligible family members shall be continuous following the death of the annuitant, or the effective date of enrollment, as applicable, so long as the surviving family members meet the eligibility requirements of Section 22775 and any regulations promulgated with respect to that section. Either a failure to timely pay the required premiums and associated costs of the coverage or the cancellation of coverage shall terminate the coverage without the option to reenroll. The contracting agency may elect to require the family members to pay all or any part of the employer premium for enrollment.

(c) This section shall apply to a contracting agency only upon the filing with the board of a resolution of its governing board electing to be subject to this section.

Billing

CalPERS will charge the employer for the survivor's full premium. This will appear on the retired portion of the Health Premium Statement. It will be the responsibility of the employer to collect from the survivor any premium due in excess of the contracted employer share.

Billing Instructions

What You Are Billed For Employers are billed on a monthly basis for the following:

Billed	For	Note
Full premium	Active employees	Member share of premium is collected by employer
Employer contribution	Retirees/Survivors (PERS or STRS)	Member share of premium is deducted from member's monthly warrant
Full premium	Retirees/Survivors (Other Non-PERS)	Member share of premium is collected by employer
Full premium	Survivors without an allowance	Member share of premium is collected by employer
Administrative fee	All subscribers, including active employees and retirees/survivors	Administrative fee is calculated on Total Active and Retired Premium

my|CalPERS Transaction Cut-Off Dates For public agencies and school employers, cut-off dates change each month. The cut-off dates are published annually in a Circular Letter.

Transactions processed after the cut-off dates will be reflected on a subsequent Health Premium Statement.

Health Premium Statement Health Premium Statements are available in my|CalPERS on or about the 15th of each month. For employers who have selected "Mail" as the Preferred Communication, a copy of the statement will also be mailed on or about the 15th. Payment is due in full on the 10th of the following month. If the 10th falls on a holiday or weekend, payment is due on the last business day prior to the 10th. Interest will be assessed on late payments (California Code of Regulations section 599.515).

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Billing Instructions, Continued

Delinquency Payment is to be paid as billed and on time, or the agency will be placed in **delinquent status** and subject to interest, penalties, premium deposits and/or termination.

CalPERS has the authority to impose interest penalties pursuant to Government Code 22899:

(c) If a contracting agency fails to remit the contributions when due, the agency may be assessed interest at an annual rate of 10 percent and the costs of collection, including reasonable legal fees, when necessary to collect the amounts due. In the case of repeated delinquencies, the contracting agency may be assessed a penalty of 10 percent of the delinquent amount. That penalty may be assessed once during each 30-day period that the amount remains unpaid. Additionally, the contracting agency may be required to deposit one-month's premium as a condition of continued participation in the program.

CalPERS also has the authority to terminate an agency's health resolution pursuant to Government Code 22939:

The board may terminate the participation of a contracting agency if it fails for three months after a demand to perform any act required by this part or by board rules or regulations.

**Reconcile
Your
Statement**

The Monthly Employer Billing Roster is located within the Billing and Payment Summary section in my|CalPERS and provides a detailed listing of health premiums billed, including adjustments, for both active and retired subscribers. Please ensure that only eligible members are enrolled in coverage and that their enrollment information, such as retirement system and medical group, is accurate.

Any discrepancies or errors will be adjusted on a future statement. You must pay the total amount billed to avoid interest and penalties.

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Billing Instructions, Continued

Remitting Payment

Check By Mail

- Please complete and return the *Remittance Slip* with your payment
- Checks should include your 10-digit *Employer CalPERS ID* number and made payable to the *California Public Employees' Retirement System*
- Send to:
 - California Public Employees' Retirement System - FRAS
 - Attn: Cashiers
 - P.O. Box 4032
 - Sacramento, CA 95812-4032
- If paying via **overnight mail**, send to:
 - California Public Employees' Retirement System - FRAS
 - Attn: Cashiers
 - 400 Q Street
 - Sacramento, CA 95811-6201

By Electronic Funds Transfer (EFT)

If you wish to use EFT, you must:

- Establish an EFT account in my|CalPERS
- Notify your bank that the CalPERS ACH ID number (**1946207465**) is assigned as an approved payee
- Allow two banking days prior to the due date for payments to be received by CalPERS on time

Multiple Accounts

If you have more than one account, you must issue separate checks and return the Remittance Slip with your payment. If you submit your remittance through EFT, you must complete separate transfers for each account.

Resources

If you have any questions or need assistance setting up your EFT account in my|CalPERS, refer to Course 107 at <https://www.calpers.ca.gov/page/education-center/employer-education/employer-training-classes/mycalpers-student-guides> or contact the CalPERS Customer Contact Center at **888 CalPERS** (or **888-225-7377**).

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