California Schools
Voluntary Employees Benefits Association (VEBA)

Administrative Policies and Procedures

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Table of Contents

Section I
Introduction

A. The purpose of this document is to provide written guidance to Employer's and their Benefits Administrators as to the rules, regulations, policies, procedures and practices of the California Schools Voluntary Employees Benefits Association (VEBA). It is not intended for distribution to VEBA Members.

B. The VEBA Administrator is the Custodial Agent designated by the VEBA Board of Directors responsible for the administration of the VEBA.

C. Plan booklets and Carrier Contracts provide detailed descriptions of the benefits and provisions of the VEBA Plans. Nothing in this document shall override the benefits and provisions described in the Carrier Contracts and Plan booklets.

D. The provisions in this document control to the extent that they are not contrary to applicable law.

E. Throughout this document, certain words or terms are capitalized and indicate a defined term or a heading.

Section II
Purpose of VEBA

A. VEBA is a voluntary, joint labor-management benefits organization. VEBA is a tax-exempt organization, established pursuant to a Trust Agreement and administered by a Board of Directors consisting of representatives of management and labor. Through VEBA, Employers and Employee Organizations/Associations work to resolve employee benefits issues seeking to provide quality health and welfare benefits at the lowest possible cost. Employers, Employee Organizations/Associations, and their Employees benefit through reduced costs and quality coverage for several reasons including:

1. Greater quality control and oversight through uniformity of plan design, purchase, and administration

2. Better plan design and more flexibility

3. Wider choice of benefits

4. Periodic member satisfaction measurement surveys

5. Lower administrative costs through combined buying power

6. Rate stability

7. Containment of future cost

8. Risk pool and buying power for both small and large groups

9. The power of cooperative shared governance

B. Health Improvement Initiatives

The California Schools VEBA is committed to offering innovative initiatives and resources to help members better manage their health. The following describes VEBA's objectives in the Health Improvement Initiatives programs:

1. Encourage prevention and early detection of disease

2. Provide disease management programs to empower members to better manage chronic conditions and illnesses

3. Provide the opportunity for members to get the right critical care treatment from the best providers available

4. Provide members greater access to health evaluation services and education programs on health-related topics

5. Coordinate activities with the member's physician when it makes reasonable sense to do so

C. VEBA does not participate as a party in Collective Bargaining between Employers and Employee Organization/Associations. Board Practices and Policies and Procedures affecting Collective Bargaining are established only in areas required to comply with legal, contractual, or sound actuarial advice.

Section III
Underwriting Rules and Regulations

A. Guidelines and Rules for VEBA Participation

1. VEBA's benefits programs pool contributions and claim experience in order to seek to deliver the best possible benefits to Employees and their families. This method avoids large swings in costs that can occur with individual Employers with smaller populations.

2. In order to deliver equity among various Employers and Bargaining/Non-Bargaining Employee Units, VEBA has established rules for determining the premium rates that will be paid into this pool. The VEBA policy reflects the following beliefs:

   a. Health care contributions for participating members should be reasonably affordable

   b. Employers which pay the full cost (or nearly the full cost) of benefits should pay a lower rate

   c. High health plan participation helps to spread the risk

   d. Opt-outs for cash (or other incentives) and/or high payroll deductions increase risk by driving healthy Employees and their Dependents out of the pool

   e. Employer health programs with low Employee participation rates may hurt VEBA's pool and, therefore, may not be appropriate candidates for participation

B. Waiver of Coverage

The following outlines provisions pertaining to Waiver of Coverage for Active Employees. All other Underwriting Guidelines and Rules continue to apply.

1. Non-Contributory

Medical coverage is mandatory for Eligible Employees if no Employee contribution is required under at least one VEBA medical plan (excluding Kaiser) offered by the Employer and Employee Organizations/Associations. An Employer and Employee Organization/Association must not allow Employees to waive non-contributory coverage, whether single or family, except under certain conditions approved in advance by the VEBA Board of Directors. If waivers are approved, the rate tiers for each medical plan for each Bargaining/Non Bargaining unit, as

applicable, will reflect the waivers.

Coverage through military benefits, Tri-Care, does not change the rule stated above.

2. Contributory

Eligible Employees may waive medical coverage, whether single or family, if the VEBA plan(s) (excluding Kaiser) offered by the Employer and Employee Organizations/ Associations require an Employee contribution. The rate tiers for each Plan for each Bargaining/Non Bargaining unit, as applicable, will reflect the waivers.

3. Waivers for Cash or Other Benefits

Waivers/Opt-outs for cash or other benefits are not allowed whether contributory or non-contributory except as provided in Section C.2.d. below.

C. Rate Tier Structures

1. VEBA provides an incentive to Employers and Bargaining/Non-Bargaining Employee Units by lowering premiums based on increasing Employer's contribution towards the health coverage. See Section X, Exhibit A for the current Rate Tier Structures.

2. The following is an overview of Employer contribution requirements for rates and plan availability:

a. Employers and each Bargaining/Non-Bargaining Employee Unit, for which Employers pay the minimum 65% of the family premium (for full- time, active Employees) may choose to offer one Kaiser plan, one UnitedHealthcare Performance HMO Package, and one UnitedHealthcare California Choice Plus PPO plan. Employer contributions between 50% and 65% will be considered for VEBA participation subject to underwriting approval.

b. Employer/Bargaining Unit participation in the VEBA where Employee contributions are greater than 35% of family coverage will be at the sole discretion of the VEBA Board. VEBA is under no obligation to offer any plans where employee contributions are greater than 35% of the family rate.

c. Direct incentives will be offered to improve Employee benefit risk practices by providing lower premiums for Employers and their Employee Units that negotiate higher Employer contributions and comply with all underwriting policies.

d. There are higher premium rates for Employers and their Employee Units that have VEBA-grandfathered cash-out programs in place. It is expected that the premium surcharge for these plans will grow significantly over the next several years due to the increasing risk being experienced in those plans. Any Employer entering the VEBA after January 06, 2010, must eliminate any cash-out and waiver programs as a condition of VEBA participation.

e. Bargaining/Non-Bargaining Employee Units will be rated on their individual Employer contribution levels, so it is possible for individual Employee Units to have different premium rates within the same Employer. (It will be possible for Employee Units within a single Employer to have different premium rates for identical benefits if they have negotiated different contribution levels.)

3. The total premium rate per Employee Unit is based on the following three factors that determine the assigned rate tier for UnitedHealthcare Performance HMO Packages:

   a. The percentage of the family premium paid by the Employer for a non-Kaiser HMO plan

   b. Whether the Employer pays cash or other benefits to Employees of the Employee Unit who waive all or part of medical coverage for themselves or dependents

   c. The percentage of active Employees and early retirees enrolled in non-Kaiser plans

4. The total premium rate per Employee Unit is based on the following three factors that determine the assigned rate tier for the UnitedHealthcare California Choice Plus PPO plan:

   a. The percentage of the family premium paid by the Employer for the UnitedHealthcare California Choice Plus PPO plan

   b. Whether the Employer pays cash or other benefits to Employees of the Employee Unit who waive all or part of medical coverage for themselves or dependents

c. The percentage of Employees covering family members in the UnitedHealthcare California Choice Plus PPO plan

D. What Employers and Bargaining Units May Select Within VEBA

1. The Employer and Bargaining/Non-Bargaining Unit may choose to offer plans to active Employees where the Employee contribution is not more than 35% of the family rate for the plan selected. At an Employee Unit level, the Employer may offer the following:

   a. One Kaiser benefit plan for active Employees and non-Medicare retirees

   b. One UnitedHealthcare Performance HMO Package for active Employees and non-Medicare retirees (San Diego County only)

   c. One UnitedHealthcare Full Network plan for active Employees and non-Medicare retirees (outside the UnitedHealthcare Performance HMO network only)

   d. One UnitedHealthcare California Choice Plus PPO Option for active Employees and non-Medicare retirees (California only)

   e. VEBA Medicare Supplement

   f. UnitedHealthcare Group Medicare Advantage (HMO)

   g. Kaiser Senior Advantage

2. For non-California Employees, Retirees, and Dependents, as permitted by state law, a package of UnitedHealthcare Out-of-Area Plans includes the Choice Plus PPO Out-of-Area plan, the EPO Out-of-Area plan, and the N/D PPO Out-of-Area plan.

3. For newly participating Employers and Bargaining/Non-Bargaining Units, all eligible plan elections must be reflected in the Participation Agreement executed by the Employer and each participating Employee Unit. Subsequently, plan elections must be made for each renewal period. The most closely-related in- force plan(s) will be continued automatically if plan elections are not made by the stated due date, (See Annual Renewal in Section IV).

Section IV
Employer Participation Provisions

A. Eligible Employers

Eligible Employers, who wish to provide benefits under this Plan for their Eligible Employees, are: School Employers (including County Offices of Education, Community College Districts and Qualified Charter Schools), Private Employers Directly Associated with VEBA, and Employee Organizations/Associations located in California. Other California Public Sector Employers may be approved for participation at the VEBA Board's discretion.

B. Required Participation Documents

Implementation of a VEBA Plan(s) requires that the following documents be executed before the coverage effective date. Implementation by an Employer without the required documentation requires prior written approval from the VEBA Co-Chairs:

1. For School District Employers, School Board Motion (Resolution of the Governing Board)

   Before or concurrent with the implementation of the benefit plan(s), evidence of governing board ratification of an Employer's participation in VEBA, and a copy of the Collective Bargaining Agreement(s), Memorandum of Understanding (MOU), or Employer Policy Statements (as applicable), should be forwarded to the VEBA Administrator. Failure to receive the required documents will be reported to the VEBA Board of Directors if they are not received within 60 days of the implementation date

2. Participation Agreements

   To participate in the VEBA, a VEBA Participation Agreement must be executed between the VEBA, the Eligible Employer and each participating Employee Unit, as shown below. VEBA medical plans must be offered as the exclusive medical plan within the Employee Unit participating in the VEBA:

   a. Collective Bargaining Unit

   b. Non-Collective Bargaining Unit

   c. Charter School

   d. Employee Organization/Association

e. Private Employers Directly Associated with VEBA

C. Documenting Practices for Collective Bargaining Units

Employers will provide to VEBA, Collective Bargaining Agreements for each participating Bargaining Unit and any internal documentation that describes any special eligibility provisions. Such documents will be attached to the Participation Agreement for Collective Bargaining Units.

D. Documenting Practices for Non-Collective Bargaining Units

Employers will provide to VEBA, Memorandums of Understanding (MOUs) or any internal documentation that describes any special eligibility provisions. Such documents will be attached to the Participation Agreement for Non-Collective Bargaining Units.

E. Additional Eligibility Rules for Charter Schools Where No Fringe Benefits Collective Bargaining Agreement Exists

In the absence of a Collective Bargaining Agreement that specifies terms and conditions, a Qualified Charter School, approved by the VEBA Board for participation, will be allowed to enroll in the VEBA plans and programs only as long as its Employees are covered by the same policies and procedures for eligibility as those Employees of the sponsoring School Employer.

F. Role of Employer in Certifying Enrollment

Each Participating Employer is directly responsible for the accuracy and administration of their enrollment in VEBA. The Employer should take all necessary steps to ensure that only Employees/Dependents legally entitled to coverage under VEBA are enrolled as part of that sponsoring organization's benefits plan.

G. Transmission of Eligibility Information

The VEBA Administrator transmits eligibility information to the VEBA carriers weekly. To ensure that identification cards and enrollment materials are received by the Employee prior to the coverage effective date, accurate and complete enrollment materials are due to the VEBA Administrator by the 15th of the month prior to the coverage effective date. New hire information should be transmitted to the VEBA Administrator as soon as completed.

H. Premium Payments

1. Premium billings are generated by the VEBA no later than the 25th of the month prior to the month of coverage. Corrections to the bill should be made by the Employer's administrator and forwarded with the Employer contributions to the

VEBA Administrator. Employer contributions are due and payable to the VEBA Administrator on the first day of the coverage month. The premiums to be paid to VEBA will at all times be governed by the executed Participation Agreement and any amendments thereto between the Employer and VEBA.

2. VEBA and Employers recognize that regular and prompt payment of contributions to the VEBA is essential to the maintenance and effectiveness of the benefits plan. Employer contributions not paid by the 20th of the coverage month are subject to liquidated damages in the amount of 2% of the unpaid balance plus interest at the interest rate which is 2% higher than the most recent quarterly investment rate paid to School Employers in San Diego County.

I. Annual Renewal

1. VEBA-approved benefits plans shall be selected in accordance with VEBA Policies and Procedures and the terms of applicable Collective Bargaining Agreements, Memorandums of Understanding, and/or Employer Policy Statements.

2. Employer/Employee Units must submit plan selections for the coming plan year no later than 60 calendar days prior to the effective date of renewal. Plan selections must be submitted in a VEBA-approved format and require Employer and Employee Unit(s) signatures as applicable.

3. In order to avoid cessation of benefits, if appropriately submitted plan selections are not received by such date, coverage will be continued under the plans most closely-related to the current year's selections. Any changes/exceptions received after 60 calendar days prior to the effective date of renewal will require VEBA Board approval.

5. Upon proper notification of the selected plans, the VEBA Administrator will provide to the Employer/Employee Unit(s), forms known as Exhibit Cs on which will be listed the requested plan selections and applicable premium rates for the coming plan year. Exhibit Cs also require sign-off by the Employer and each Employee Unit as applicable.

J. Verification Procedures (Revised 5/2013)

1. The Board of Directors for the California Schools VEBA may, at its discretion, instruct the VEBA Administrator or other Board designee, to complete an annual review of the benefits program practices used by a Participating Employer to ensure compliance with the VEBA Establishment Agreement, VEBA Board Practices, the Participation Agreement, and the guidelines contained in the VEBA Administrative Policies and Procedures. Any corrective action required as a result of the failure to comply by a Participating Employer will be at the discretion of the Board of Directors as outlined in the VEBA Establishment Agreement and the Participation Agreement.

2. Furthermore, to ensure that enrolled Dependents meet the requirements of the VEBA, Participating Employers must cause a Dependent Eligibility Verification Audit to be conducted.

3. An Employer may meet this requirement by complying with the following:

    a. The Employer may contract with a Company that demonstrates, to the VEBA Administrator, administrative capability of conducting such Audit, or

    b. The Employer may conduct a self-audit by receiving pre-approval of their Audit plan from the VEBA Administrator.

4. To meet VEBA standards, the entity conducting the Audit must obtain from the Employee, legal documents sufficient to verify that the Dependent is eligible for coverage; i.e., marriage certificate, Domestic Partnership documents, birth certificate, applicable court documents certifying adoption, guardianship or legal custody, medical certification for an over-age disabled child, etc.

5. An Employer may give Employees the opportunity to delete no-longer eligible Dependents prior to conducting the Verification Audit.

6. Dependent Eligibility Verification Audits must be completed in accordance with the following timeframes:

    a. Within the first twelve (12) months of participation for Employers new to VEBA;

    b. Once every five years for Employers having completed an approved Audit with an ineligible dependent rate of less than three percent (3%) (Revised 6/2016);

    c. Once every year for Employers having completed an approved Audit with an ineligible dependent rate of equal to or greater than three percent (3%) (Revised 6/2016).

7. When determination is made that an employee or dependent has failed to provide documentation supporting enrollment in a VEBA program or the documentation indicates that the member does not qualify, the employer will issue termination instructions to the VEBA within 90 days of the completion of the audit. Continued coverage of those individuals who are not qualified beneficiaries under Federal law may subject the non-qualified beneficiary and the employer to significant financial risk. Failure to adequately enforce Federal enrollment guidelines may result in:

    a. Employee or dependent being denied coverage at the time of a catastrophic event (Revised 8/2017);

    b. Unpaid income taxes for the value of benefits provided for the employee or

dependent (Revised 8/2017);

c. Termination of participation in VEBA for the non-compliant employer (Revised 8/2017);

d. Financial indemnification sought by VEBA from the Employer (Revised 8/2017);

e. Increased premium rates paid to the VEBA (Revised 8/2017).

Options to be pursued for non-compliance will be at the discretion of the VEBA Board. (Revised 8/2017)

8. The audit results are final and outcome cannot be changed. At the completion of the audit, a final report will be issued to the contract signatories. The Employer will have 90 days to address those found ineligible before noncompliance options are pursued. (Revised 8/2017)

K. VEBA's Involvement in the Collective Bargaining Process

The California Schools VEBA does not participate as a party in Collective Bargaining between Employers and Employee Organizations/Associations. Certain aspects of coverage by the VEBA may affect bargaining issues. As a general rule, VEBA's contracts with health care insurers do not permit midterm modifications in VEBA's plan of benefits. Employers, Employee Organizations/Associations, and insurance committees are encouraged to contact the VEBA Administrator for clarification of any VEBA rules, regulations, or policies that may affect Collective Bargaining.

L. Plan Changes

The Board of Directors reserves the right to change or modify VEBA's benefits plans in the event the contributions to VEBA or its reserves are insufficient. The Board also reserves the right to refuse any contributions from any Employer under any Collective Bargaining Agreement or Participation Agreement that contains terms inconsistent with the VEBA Establishment Agreement.

Administrative Policies and Procedures

M. Termination of Participation in the VEBA

1. An Employer may terminate participation in the VEBA by giving written notice received at VEBA no later than 90 days prior to the end of the current plan year. Because VEBA endeavors to provide the highest quality services to all its members including adequate administrative support to the member Employers at renewal, VEBA does not recognize conditional terminations. A conditional termination (one that reserves the right to rescind the termination and reestablish VEBA membership) will be rejected. The termination notice does not have to specify a reason for termination, but must be signed by all parties to the Participation Agreement. Inadequate or incomplete termination notices will be rejected and coverage renewed for the coming plan year.

2. An Employer will be prohibited from reapplying for VEBA membership for a period of three years subsequent to terminating membership in the VEBA.

Section V
Employee/Dependent Participation Provisions

A. Eligibility

1. An individual is eligible for benefits under the VEBA Plan(s) as defined in the provisions set forth in the respective Collective Bargaining Agreement and/or Employer's Administrative Policy, including Memorandums of Understanding. In the absence of such an Agreement and/or Policy this document shall govern eligibility as specified below.

2. Dual Coverage Exclusion Option

   In recognition of current budgetary concerns of School Districts and their Employee Organizations/Associations, and upon agreement of the District and the applicable Employee Organization/Association, the VEBA will allow the exclusion of dual coverage under VEBA medical plans for an Employee who is legally married to an Employee of the same School District and for an Employee who has a Domestic Partner who is an Employee of the same School District. Dual Coverage is defined as an individual who is covered under a VEBA medical plan both as an Employee and as a Dependent. Election of this Dual Coverage Exclusion Option is subject to the following:

   a. To authorize implementation of this Exclusion Option, a copy of the Collective Bargaining Agreement, Memorandum of Understanding, or Employer's Administrative Policy, as applicable, must be provided to the VEBA

   b. Effective dates for School Districts and their Employee Organizations/Associations who elect this Exclusion Option on or after September 1, 2009, will become concurrent with the start of the following Plan Year

   c. No retroactivity will be allowed

   d. In the event the Employee/Retiree carrying the coverage as the subscriber under this Exclusion Option loses Eligibility for coverage, the Employee/Retiree covered as a Dependent must be allowed to become the subscriber, provided such Employee/Retiree meets the VEBA's definition of Eligible Employee/Retiree

B. Eligible Employees

Except under the conditions specified in A.2., above, Eligible Employees of Employers participating in the California Schools VEBA are as follows:

1. Full-Time Employees

An Employee is considered a Full-time Employee if the Employee's services fall within the definition set forth in the respective Collective Bargaining Agreement. If the Employee is not covered by a Collective Bargaining Agreement, he or she will be considered a Full-time Employee if he or she meets the Employer's definition.

2. Part-Time Employees

An Employee is considered a Part-time Employee if the Employee's services fall within the definition set forth in the respective Collective Bargaining Agreement. If the Employee is not covered by a Collective Bargaining Agreement, he or she will be considered a Part-time Employee if he or she meets the Employer's definition.

3. Employees on Employer-Approved Leave of Absence

An Employee on Employer-approved paid Leave of Absence is entitled to benefits under this Plan. An Employee on Employer-approved unpaid Leave of Absence is eligible to continue coverage subject to the provisions of this Plan and this document, but may be subject to self-pay provisions.

4. School Board Members

Duly elected School Board Members are considered Employees of Participating Employers and, as such, are entitled to benefits under this Plan. As specified under the Employer Policy, the School Board Member may be subject to self-pay provisions.

5. Qualified Charter School Employees

a. Charter School Employees and their Dependents may be eligible for benefits under this Plan if such coverage is allowed under any Collective Bargaining Agreement, Memorandum of Understanding, Charter School Contract between the sponsoring School Employer and the Charter School, or a direct contract between the Charter School and the VEBA.

b. Additionally, to be eligible for benefits, the VEBA Carrier Contract and the VEBA Administrative Policies and Procedures must allow for such coverage.

c. To be eligible for VEBA participation, the Charter School must execute a VEBA Participation Agreement, must not offer non-VEBA medical programs to its Employees, and must adhere to the Underwriting Rules and Regulations of VEBA. For Charter Schools that have selected the sponsoring School Employer as the Employer for collective bargaining purposes, Employee and Dependent eligibility will be governed by the collective bargaining rules and regulations in effect between the Employee Organization/Association and the sponsoring School Employer. For Charter Schools that have selected the Charter School as the Employer for collective bargaining purposes, to ensure that the Charter School policies are in conformance with the VEBA Underwriting Rules and Regulations, the Charter School must provide its eligibility rules to the VEBA in a format acceptable to the VEBA. Charter School participation is subject to the sole discretion of the VEBA Board.

6. Employee Organization/Association Staff Members

Employees of Employee Organization/Association offices and their Dependents may be eligible for benefits under the VEBA plan(s). To qualify for participation in VEBA, the Employee Organization/Association must execute a VEBA Participation Agreement, and must adhere to the underwriting rules and regulations of the VEBA. No non-VEBA medical plans may be offered.

7. Retirees

Retirees may be entitled to continue benefits through participating Employers for themselves and their Eligible Dependents if such coverage is allowed under the Collective Bargaining Agreement, Memorandum of Understanding, Employer's Administrative Policy, the Carrier Contracts, and all applicable administrative requirements. A Retiree may be required to pay the premium due to continue coverage. If the Retiree fails to pay the appropriate premium as required and/or otherwise fails to comply with Plan provisions, the Retiree will not be eligible to participate in the VEBA Plan(s). If Retiree coverage is allowed to terminate, reinstatement will not be permitted.

Additionally, a VEBA Post-65 Retiree Plan is offered directly through VEBA under conditions specified in Section VIII.

8. Military Reservists Called to Active Duty

   If an Employee is participating in a VEBA benefits plan at the time that he/she is called up for active duty, that Employee and/or Dependent may continue benefits for up to twenty-four (24) months. The Employee may be responsible for premium payment.

9. Employees of Private Employers Directly Associated with VEBA

   Employees of Private Employers Directly Associated with VEBA and their Dependents may be eligible for benefits under the VEBA plans(s). To qualify for participation in VEBA, such Private Employers must execute a VEBA Participation Agreement and must adhere to the underwriting rules and regulations of the VEBA. No non-VEBA medical plans may be offered. Private Employer participation is subject to the sole discretion of the VEBA Board.

10. Employees of Other Public Sector Employers

    Employees and their Dependents may be eligible for benefits under the VEBA plans(s). To qualify for participation, such Public Sector Employer must be approved by the VEBA Board, execute a VEBA Participation Agreement, and must adhere to the underwriting rules and regulations of the VEBA. No non- VEBA medical plans may be offered. Other Public Sector Employer participation is subject to the sole discretion of the VEBA Board.

C. Eligible Dependents

1. A Dependent is eligible for benefits pursuant to the Collective Bargaining Agreement, Memorandum of Understanding, or Employer's Administrative Policy applicable to the Eligible Employee. The term Dependent is defined in the contractual provisions of the elected insurance Plan Document. This Document, Carrier Contracts, Collective Bargaining Agreements, or Employer Policy may limit Dependent coverage. Acceptable documentation of Dependent eligibility may be required; i.e., marriage/birth certificates, etc.

2. An Employee's spouse or an Employee's same-sex partner or opposite-sex partner (whether through marriage, civil union, or domestic partnership approved by the State of residence) is eligible for coverage as a Dependent on the Employee's plan. (Revised 9/2019)

3. Except under the conditions indicated in A.2. above if an individual and his or her spouse/same-sex partner/opposite-sex partner are both Eligible Employees, each shall be eligible for coverage as both an Employee and as a Dependent. (Revised 9/2019)

4. If both parents of an Eligible Child are Employees, such Child shall be eligible as a Dependent of each parent.

5. A Child of an Employee/spouse/Domestic Partner is eligible for coverage on the Employee's plan from birth to the end of the month in which the Child reaches age 26. Eligible Children include a natural child, step child and other Special Dependent Categories specified below.

6. Special Dependent Categories

   a. Guardianship

      VEBA allows the enrollment of a Child for whom the Employee is named legal guardian. Guardianship must be supported by a Court Order, a copy of which must be attached to the enrollment or change form submitted at the time of enrollment. To obtain coverage, a Dependent must be properly enrolled within 31 days of the effective date of the Court Order, or wait until the next Open Enrollment Period to enroll for coverage. A Dependent is not entitled to enroll for coverage under temporary guardianship orders or fost-adopt placements.

   b. Adoption

      VEBA allows the enrollment of a Child placed for adoption if necessary enrollment procedures are completed by the Employee within 30 days of placement for adoption. A copy of the placement document must be submitted to the VEBA Administrator with the enrollment form. VEBA will also allow the enrollment of a Child within 30 days of the adoption being finalized. A copy of the formal court order must be submitted to the VEBA Administrator with the enrollment form.

   c. Grandchildren

      Grandchildren are not eligible as Dependents under the VEBA plan if permanent legal guardianship has not been established.

   d. Handicapped Child

      Under conditions specified by Carrier Contracts and upon acceptable physician certification, an Employee's Dependent Child who is incapable of self-sustaining employment by reason of mental retardation or physical handicap, incurred prior to age 26, and who is primarily dependent upon the Employee for support and maintenance is eligible for coverage beyond the maximum age limitation of this Plan.

e. Domestic Partner Coverage

VEBA offers Domestic Partner Coverage under either of the following two eligibility provisions:

(1) Employees/Retirees may qualify for Domestic Partner Coverage by having registered the Domestic Partnership with the State of California and providing to the VEBA a copy of the registration

(2) An Employee/Retiree who has not registered the Domestic Partnership with the State of California may qualify for Domestic Partner Coverage by filing a Declaration of Domestic Partnership with the VEBA

See Section VII for Domestic Partner eligibility and enrollment provisions and Section X, Exhibit B for enrollment and disenrollment forms.

Section VI
Timing of Employee and Dependent Coverage

A. Effective Date of Coverage

Provided appropriate enrollment forms are submitted within the required timelines, coverage will become effective in accordance with the following:

1. New or Newly Eligible Employees

Coverage will become effective for Eligible Employees and their Eligible Dependent(s) on the first of the month following the date of initial eligibility or on the first working day, if so enumerated in the Employer's VEBA Participation Agreement, subject to the contractual provisions of the elected insurance plan. Different effective dates may be collectively bargained subject to the VEBA's approval.

2. School Board Members

If coverage is desired, School Board Members must enroll in the VEBA Plan(s) within 31 days of the Employer's first entering the VEBA Plan(s), within 31 days of assuming office, or at any Open Enrollment period. Board Members will be considered Management Employees with respect to the application of Employer enrollment rules as defined in the Participation Agreements with VEBA.

3. Open Enrollment Period

Eligible Employees may enroll for coverage and/or add Eligible Dependents at times other than those specified above during an Open Enrollment Period. Open Enrollment Periods are limited to one per calendar year unless there has been a collectively bargained change in benefits. A change in the Employer's Open Enrollment Period requires the prior approval of the Participation Agreement signatories and the VEBA Co-Chairs, and such a request must be in compliance with the executed Participation Agreement.

4. Adding Newly Eligible Dependents after an Employee's Coverage Effective Date

Newly Eligible Dependents may be enrolled under a covered Employee's Plan in accordance with the following requirements and timelines; however, if the Employee opts to enroll a new Dependent and the addition affects a contract-type (single to two-party, or two-party to family coverage) a premium increase will be required. The premium increase is effective the first of the month following the effective date of coverage if the effective date of coverage for the new Dependent is the second day or after of the preceding month. A full current month's premium is due for a newly added Dependent whose coverage is effective on the first day of

any given month.

a. New Marriage

The new spouse of an Employee may be enrolled in VEBA on the 1st of the month following the date of marriage, unless another effective date has been collectively bargained. However, except as provided under the Special Enrollment Option in A.5 below, unless the Employer and VEBA are notified within 31 days of the date of marriage, the new spouse may not be enrolled for coverage until the next Open Enrollment Period. An acceptable copy (as determined by the Employer) of a certificate of marriage must be attached to the enrollment form.

b. Newborn Coverage

In accordance with California law, a newborn is automatically covered as of his or her birth date to the end of the birth month. If the Employee elects to continue coverage past the end of the newborn's birth month, the Employee must enroll the newborn by completing and submitting the appropriate enrollment form and copy of the birth certificate within the first 31 days of the date of birth. (See Plan booklet for administrative procedures to acquire this coverage.)

c. Adoption

Coverage for a child placed for adoption becomes effective the date of placement if appropriate enrollment forms are submitted within 30 days of the date of placement, or, on the date the adoption becomes final if enrollment forms are submitted within 30 days of finalization. A copy of the formal Court Order must accompany the enrollment form.

d. Court-Ordered Coverage

The Knox Keene Act (part of the Health and Safety Code) and the Insurance Code require regulated plans to enroll children or a spouse under a member's plan without regard to Open Enrollment periods if ordered by a court, provided that a request for coverage is made within 30 days of the Court Order. Although VEBA is exempt from Knox Keene and certain Insurance Code provisions, VEBA will honor the late enrollee provisions imposed on other plans by this legislation.

e. Domestic Partner Coverage

Enrollment of Domestic Partners and/or child(ren) of Domestic Partners must occur within very specific time frames. See Section VII for more detailed information and requirements.

5. Special Enrollment Option (HIPAA)

a. Under the Health Insurance Portability and Accountability Act (HIPAA), an Employee/Domestic Partner or his/her Dependent(s), who initially declined to enroll in an Employer's health plan, must be allowed to enroll during the Plan year if they meet the below described conditions:

(1) The Employee gains a Dependent through marriage, birth, adoption, or placement for adoption

(2) The Employee, spouse, Domestic Partner, or other Dependent(s) loses other coverage through another employer (e.g., due to legal separation, divorce, death, termination of employment, reduction in hours, termination of contributions for coverage by the other employer, or completion of the maximum COBRA continuation period)

(3) The Employee must make a request to the Employer to exercise this Special Enrollment Option. The Employee must request coverage within 30 days of the event as noted above

b. Coverage is effective as of the date of the event (i.e., birth, adoption, or placement for adoption), except for marriages. Coverage for a spouse in the event of marriage is effective on the first of the month following the date of the request.

c. Members otherwise eligible for a VEBA Plan who choose to disenroll from another plan do not qualify for this Special Enrollment Option and are treated as late enrollees. As such, the Employee or his/her Dependents may not enroll in the Plan except during the annual Open Enrollment Period (unless he or she qualifies for the special 30-day enrollment period cited earlier).

d. For additional HIPAA provisions and requirements see Section IX E.

B. Termination of Coverage

Coverage for an Employee/Retiree and his/her Dependent(s) will terminate in accordance with provisions of the applicable Collective Bargaining Agreement, Memorandum of Understanding, Employer Administrative Policy, or subject to the contractual provision of the insurance plan. Different termination dates may be collectively bargained subject to the VEBA's approval. (For termination provisions of the VEBA Post-65 Retiree Plan see Section VIII.)

1. Employee/Retiree

Subject to the continuation provisions of COBRA and Education Code Section 7000 et seq., unless a different termination date is specified in the Collective Bargaining Agreement, Memorandum of Understanding, or Employer's Administrative Policy, an Employee's/Retiree's eligibility for VEBA benefits ceases at the end of the month in which one of the following events occurs:

a. The Employee's/Retiree's Employer ceases to participate in the VEBA

b. The Employee enters full-time military, naval, or air service and is not part of a call back to active duty of military reservists

c. The required contributions are no longer made to the Plan

d. The Employee/Retiree is no longer eligible under the contractual provisions of the Carrier Contract

e. The Employee/Retiree ceases to be eligible for benefits under the Collective Bargaining Agreement, Memorandum of Understanding, or Employer's Administrative Policy

f. Retiree coverage that terminates may not be reinstated unless the Retiree requalifies for coverage as an active Employee

2. Dependent(s)

Subject to the continuation provisions of COBRA and Education Code Section 7000 et seq., unless a different termination date is specified in the Collective Bargaining Agreement, Memorandum of Understanding, or Employer's Administrative Policy, Dependent coverage ceases at the end of the month in which one of the following events occurs:

a. The Employee, Retiree or former Employee ceases to be eligible for coverage

b. The Dependent ceases to be eligible as a Dependent as set forth in the provisions of the elected insurance contract, Collective Bargaining Agreement, Memorandum of Understanding, or Employer's Administrative Policy

c. The Employee's, Retiree's, or former Employee's spouse becomes ineligible for coverage when the Employee and spouse become legally divorced, legally separated, or the Employee/Retiree dies. The termination date will occur as follows:

(1) The last day of the month in which the divorce decree is final

(2) The last day of the month in which legal separation is determined

(3) The last day of the month in which the Employee's/Retiree's death occurs

d. Coverage for a Child, including the Child of a Domestic Partner, will terminate at the end of the month in which the child reaches age 26 unless the Child qualified under the Special Dependent Categories specified in Section V C.6.d. above.

e. Domestic Partner coverage will cease in accordance with Section VII.

3. Cessation of Required Employee Contribution

Employees may be required to pay a portion of the cost of their benefits pursuant to the applicable Collective Bargaining Agreement, Memorandum of Understanding, or Employer's Administrative Policy. Coverage will terminate at the end of the last month for which the required Employee contribution was made for Employee and/or Dependent coverage. If coverage is allowed to terminate, the Employee will not have the opportunity to again enroll for coverage until the next Open Enrollment Period.

C. Retroactivity

Retroactive enrollment/disenrollment is limited to 60 days by the Carrier Contract. The VEBA Administrator may grant exceptions in cases where the Employee has completed all necessary enrollment/disenrollment steps and an error on the part of the Employer, Carrier, or VEBA Administrator prevented proper enrollment or disenrollment. Effective January 2014, in accordance with the Patient Protection and Accountability Act (PPACA), no retroactivity will be allowed.

D. Employee Responsibility to Notify of Eligibility Changes

An Employee should notify the Employer of any eligibility changes that will result in termination of coverage for the Employee or any of their Dependents within 10 days of the event leading to the loss of eligibility. The Employer should immediately notify the VEBA Administrator to facilitate proper disenrollment of the Employee or Dependent.

E. Consequences of Continuing Coverage for Ineligible Dependents

1. In situations where benefits have been paid or overpaid to ineligible beneficiaries, e.g., benefits continue to be paid for a spouse following a divorce which has not been disclosed to the Employer, the member is responsible for the cost of benefits from the appropriate coverage termination date had the loss of eligibility been properly reported.

2. At the discretion of VEBA, the member will be required to make payment in accordance with one of the following:

    a. Pay to the Carrier, the cost of all services rendered, or

    b. Pay to VEBA, premium payments in an amount equivalent to the COBRA premiums from the date the dependent became ineligible through the end of the COBRA coverage period. These payments shall not be considered COBRA qualifying payments as such because no retroactive COBRA shall be granted

3. Failure to pay these premiums may result in severe financial consequences to the member, including but not limited to, Federal tax implications, State tax implications, and financial exposure to the VEBA Trust.

Section VII
Provisions Related to Domestic Partner Coverage

A. Domestic Partner Coverage

1. An Employee/Retiree may provide coverage for an eligible Domestic Partner and/or the Partner's Eligible Children by submitting appropriate enrollment forms within required timelines.

2. The VEBA will make coverage available for both same- and opposite-sex Domestic Partners. Under current California law, eligibility for Domestic Partner coverage must be expanded to include both same- and opposite-sex partners. (Revised 9/2019)

3. If an Employee/Retiree chooses to enroll his/her Domestic Partner, he/she will be able to choose from the medical and, if applicable, dental or vision care plans offered by insurers who have agreed to provide coverage for Domestic Partners.

4. Under the VEBA Plans, the coverage for a Domestic Partner and his/her Eligible Children is the same available to the legally married spouse of an Employee/Retiree and subject to the same terms and conditions.

B. Possible Tax Implications of Domestic Partner Coverage

1. An Employee who provides Domestic Partner coverage will have added to his/her taxable income for purposes of federal income taxation, the fair market value of the health coverage accorded the Domestic Partner and/or his/her Dependents, (less any contribution paid by the Employee for this coverage) subject to withholding, unless it can be demonstrated that the Domestic Partner and/or his/her Dependents qualify as a Dependent of the Employee for federal income tax purposes.

2. State taxes may apply if the Employee and Domestic Partner fail to register with the state of California or other applicable state where they reside.

3. An Employee may want to consult an attorney concerning any possible income tax implications of providing Domestic Partner coverage.

4. Neither the District nor the California Schools Voluntary Employees Benefits Association or any employee or agent can definitely identify the tax consequences.

C. Eligibility

VEBA offers Domestic Partner Coverage under either of the following two eligibility provisions:

1. Employees/Retirees may qualify for Domestic Partner Coverage by having registered the Domestic Partnership with the State of California and providing to the VEBA, a copy of the registration.

    a. For Domestic Partners registered with the State of California, a properly completed enrollment form and copy of the registration endorsed as filed by the California Secretary of state must be submitted to the Employer/Plan Administrator within required timelines outlined below.

    b. An Employee may enroll his/her Domestic Partner and/or the Partner's Eligible Dependent Children by submitting the required enrollment forms for Domestic Partner Coverage within

        (1) 31 days of the date of hire, or

        (2) For a continuing Employee newly eligible to enroll for benefits coverage, within 31 days of attaining eligibility, or

        (3) Within 31 days of registration with the State of California, or

        (4) The Employer's annual Open Enrollment Period; the effective date must coincide with the beginning of the Employer's Plan Year

2. An Employee/Retiree who has not registered the Domestic Partnership with the State of California may qualify for Domestic Partner Coverage by fulfilling the following requirements and filing a Declaration of Domestic Partnership with the VEBA. (See Section X, Exhibit B for Domestic Partner forms.) Enrollment under this eligibility provision may only be accomplished during the Employer's annual Open Enrollment Period.

    a. The Employee and his/her Domestic Partner must

        (1) Both be at least 18 years old, and

        (2) Not legally married to anyone, and

        (1) Have had at least twelve complete months between the date of the termination of any prior marital status or domestic partner relationship and the date of the domestic partner application is submitted, and

(3) Reside in the same residence, with the intent to reside together permanently, and

(4) Have the mental competence to contract, and are not related by blood to the degree that would bar marriage under California law, and

(5) Have resided together continuously for the twelve complete months preceding their application for coverage, and

(6) Have agreed to be jointly responsible for basic living expenses, including food, shelter, and other expenses of the joint household, and

(7) Have terminated any prior domestic partnership at least twelve complete months prior to application for coverage, and

(8) Have filed a fully complete application, together with attachments.

b. The Application must be accompanied by any one of the following to establish joint residence:

(1) Copies of driver's licenses for both individuals which contain the same address, or

(2) Mortgage documents or deed containing the names of both individuals, or

(3) Rental lease agreement containing the names of both individuals

c. The Application must be accompanied by any one of the following to establish financial interdependence:

(1) Joint checking or savings account, or

(2) Credit cards with the same account number in both names, or

(3) Common ownership of real property or a common leasehold interest in real property, or

(4) Common ownership in a motor vehicle, or

(5) Joint wills in which one partner is the primary beneficiary under the other partner's will, or

(6) Designation of both partners as authorized signatories on safe deposit boxes, or

(7) Designation of the Domestic Partner as the beneficiary under the Employee's life insurance Plan

D. Cessation of Domestic Partner Coverage

1. The Employee and/or the Domestic Partner has a responsibility to notify the Employer/Plan Administrator of the termination of the Domestic Partnership within (30) days of the first to occur of the following:

   a. The death of the Domestic Partner

   b. The date on which any of the criteria of a Domestic Partnership relationship is no longer met

   If the Employee fails to make the required notification, the Employee will be liable for any expenses incurred by the VEBA with respect to the former Domestic Partner or his/her Dependents after the termination of the Partnership and must reimburse the VEBA for the value of those benefits. The VEBA shall have the right to recover attorney fees and costs incurred in collecting such expenses from the Employee**.**

2. Coverage for a Domestic Partner and his/her Eligible Dependent Children will cease on the first to occur of the following:

   a. The end of the month in which the death of the Domestic Partner occurs

   b. The end of the month in which one or more of the criteria of Domestic Partnership is no longer met

   c. The end of the month for which a required Employee contribution is made for coverage for a Domestic Partner or his/her Dependents

   d. Under current law, a Domestic Partner and his/her Dependents are not eligible for COBRA continuation coverage upon cessation of VEBA coverage; however a limited conversion plan may be available through the medical plan carrier.

The VEBA makes a COBRA-type continuation coverage option available to California-registered Domestic Partners who would otherwise lose VEBA coverage. A formal joint request must be made to the VEBA by the Employer and Employee Organization(s), as applicable, for this coverage option to be implemented.

VEBA Domestic Partner continuation coverage is not COBRA continuation coverage: however, the VEBA will mirror COBRA qualifying events, enrollment, and termination provisions. Employers will be responsible for facilitating notification, billing and collecting premiums and must report eligibility and termination dates to the VEBA within required timelines for reporting COBRA participants.

E. Modification or Termination of Policy

The VEBA Board of Directors in the exercise of its sole and unreviewable discretion expressly retains the sole and unfettered right at any time and from time to time to interpret this policy to apply this policy, to terminate this policy, to modify this policy, to change or add to the eligibility requirements of this policy, to change or add or decrease the VEBA programs in which Domestic Partners may participate, and to cease providing some or all VEBA benefits to Domestic Partners upon thirty days advance notice, as permitted by applicable law. (Revised 9/2019)

Section VIII
Provisions Related to VEBA Post-65 Retiree Plan

A. VEBA makes a medical plan option available to certain individuals enrolled in and eligible to receive Medicare A & B benefits.

Eligible Employees/Dependents are as follows:

1. Former Employees that have separated from a VEBA-Participating Employer

2. Active, part-time, non-benefited Employees employed by a VEBA-Participating Employer

3. Eligible Dependents (including surviving spouses) of former Employees and active, part-time, non-benefited Employees specified above

Participation in this option may be on a self-pay basis and must be paid monthly to the VEBA on a timely basis.

B. Eligible Employees/Dependents may enroll in the VEBA Post-65 Retiree Plan under the following conditions:

1. All enrollees must have Medicare A & B benefits in effect upon activating enrollment

2. The Employee's employer must be a VEBA-Participating Employer at the time of application for enrollment in the VEBA Post-65 Retiree Plan

3. The Employee/Dependent must reside in the CMS-approved service area of the Plan selected

4. Application for enrollment in the VEBA Post-65 Retiree Plan must be submitted as follows:

   a. For separating Employees (and/or their Dependents) eligible and enrolled to receive Medicare A & B benefits at the time of the Employee's separation from employment, application must be made within 31 days of such separation

   b. For separated Employees (and/or their Dependents) who, at the time of the Employee's separation from employment, have not yet met eligibility requirements to receive Medicare A & B benefits (i.e., age, etc.), application must be made within 31 days upon first becoming eligible to enroll for Medicare benefits

c. For active, part-time, non-benefited Employees (and/or their Dependents), application must be made within 31 days of first becoming eligible and enrolled to receive Medicare A & B benefits

d. For Employees/Dependents enrolled in Employer continuation coverage programs (i.e., COBRA, early retirement plans, etc.), application must be made within 31 days of ceasing such continuation coverage

e. Upon carrier approval, a Special Enrollment Period may be available, to Eligible Employees/Dependents of an Employer who joins the VEBA after the initial offering of the Plan

C. Termination of Coverage

1. Coverage under the Plan will terminate on the first to occur of the following:

a. the end of the month for which the last required contribution is made

b. upon termination of Medicare A & B

c. upon assignment of Medicare A & B benefits to another carrier

d. upon no longer residing in a CMS-approved service area of the Plan selected

2. In the event that an Employer terminates VEBA participation, coverage for an Employee/Dependent enrolled in the Plan prior to such termination will remain in effect.

D. VEBA also makes a voluntary dental plan option available to individuals who elect to enroll for medical coverage. The coverage is not available on a stand-alone basis, but available only as an add-on to the medical coverage. Eligibility and enrollment in the dental plan is subject to the same terms and conditions listed above except that Medicare A & B benefits eligibility is neither applicable nor required.

Section IX
Federal and State Regulations and Regulatory Resources

A. Member Appeals

1. The VEBA Board does not make medical judgments.

2. VEBA Board reviews are limited to determining whether Carrier Contracts are being effectively adhered to by contracting providers.

3. The Carriers providing benefits to VEBA members will administer appeals from adverse benefit determinations in accordance with the requirements mandated by the Health Care Reform Act. Refer to Carrier Plan Documents for appeal/dispute resolution procedures.)

B. Converting Coverage to an Individual Policy Directly with the Carrier

If medical insurance provided through a group policy terminates for any reason other than termination of the policy by VEBA, the individual may have issued, without medical examination, an individual policy of insurance, provided application is made and premium paid to the insurance company for such policy within 31 days after the termination of insurance. This conversion plan is obtained directly through the carrier and is not subject to the rules and regulations of VEBA or the Employer and costs and coverage may vary significantly.

C. Continuation Coverage for Retired Certificated Employees and spouses (Ed. Code Section 7000 also known as AB528)

In accordance with California Education Code Section 7000, et. seq., upon retirement and/or expiration of COBRA coverage, a Participating School Employer must allow a certificated Retiree and eligible spouse to have the option of continuing medical and dental coverage if the Retiree meets the following criteria:

1. The employee retired from the Employer as a member of any public employee retirement system

2. If an individual is the surviving spouse of a certificated employee/retiree, that individual also is eligible to continue coverage

3. Coverage will be provided at the individual's own expense

4. A retiree or surviving spouse who elects coverage under this provision and who subsequently terminates coverage for any reason will be prohibited from obtaining coverage at a later date

D. Medicare Secondary Payer Program

1. By law, employer health plans generally must pay the Medicare-related benefits first, before Medicare does, for the following individuals:

   a. Active employees over age 65 and over-age-65 spouses of active employees of any age

   b. Medicare-disabled beneficiaries who are receiving employer health coverage by virtue of the plan participant's current employment status

   c. Certain employees and dependents suffering from end-stage renal disease

2. Failure to conform to these Medicare Secondary Payer rules can result in substantial civil and tax penalties being imposed against an employer, including a private cause of action by employees.

E. Consolidated Omnibus Budget Reconciliation Act (COBRA)

1. Congress enacted the Consolidated Omnibus Budget Reconciliation Act (COBRA) in 1985. With the intent of shifting medical costs from the federal government to the private sector, COBRA includes the requirement that most employers allow individuals who would otherwise lose their employer-provided health coverage, due to certain Qualifying Events, the right to continue that coverage for specified periods of time to allow the individual a transition period to obtain other coverage. COBRA became effective the first day of a plan year on or after July 1, 1986 and has had numerous legislative revisions since then.

2. The Internal Revenue Service (IRS) issued Proposed COBRA Regulations in 1987 and in 1998, providing some guidance to the COBRA law, but the first "Final" COBRA Regulations were not issued until February 1999. Additional "Final" Regulations have been issued in 2001 and 2004. For topics not addressed in the Final Regulations, the plan and the employer "must operate in good faith compliance with a reasonable interpretation of the statue."

3. Employers Who Must Comply

   a. Employers who had 20 or more employees on 50 percent of its typical business days during the preceding calendar year must comply with COBRA. COBRA Regulations specify that both full- and part-time employees count regardless of their eligibility for the group health plan. Part-time employees are counted as a fraction of full time.

b. The IRS has responsibility for auditing employers to determine an employer's compliance with COBRA Continuation Coverage requirements. Non-compliance penalties may be assessed.

4. Individuals Eligible to Elect COBRA Continuation Coverage

a. An individual eligible for COBRA Continuation Coverage is known as a Qualified Beneficiary. A Qualified Beneficiary is an individual who was covered under the employer's group health plan the day before a COBRA Qualifying Event takes place and includes the following:

(1) A covered employee

(2) The covered spouse of the employee

(3) The covered dependent child of the employee. (If the covered employee elects COBRA Continuation Coverage, any child born to, or placed for adoption with, the covered employee during the period of COBRA Continuation Coverage is also considered a Qualified Beneficiary if the child is enrolled on the Plan)

b. Each Qualified Beneficiary (covered individual) who would otherwise lose coverage due to certain Qualifying Events has the same rights under the group health plans as a "similarly situated active employee".

c. When a Qualifying Event occurs, each Qualified Beneficiary is entitled to make a separate election with regard to continuing any or all of the group health insurance benefits he/she was receiving immediately before the Qualifying Event.

5. COBRA Qualifying Events

COBRA must be offered if a Qualifying Event occurs that causes a loss of coverage under the group health plan. A loss of coverage means the individual ceases to be covered under the same terms and conditions as in effect immediately before the Qualifying Event and includes any increase in the employee premium or contribution if the increase is tied to a Qualifying Event. (The loss of coverage does not need to occur immediately after the Event.) The actual date of the Event is generally accepted as the Qualifying Event Date; however, OBRA of 1989 amended COBRA time frames to allow Employers to use the loss of coverage date as the date of the Qualifying Event. Whichever date is used, it is essential that employers apply that date consistently.

a. The following Qualifying Events, that would cause a covered employee and his/her covered dependents to lose coverage, entitles each individual to COBRA Continuation Coverage for 18 months from the date of the Event:

(1) The employee's termination of employment for any reason other than "gross misconduct". (The IRS has not provided a definition of gross misconduct and has stated that they do not plan to provide one)

(2) The employee is laid off

(3) Reduction in hours of the employee, i.e., full-time to part-time, strike

(4) Leave of absence, except that a FMLA leave of absence (Family and Medical Leave Act) becomes a Qualifying Event on the last day of the leave if the employee does not return from the leave

(5) The Employer's bankruptcy

b. The following Qualifying Events, that would cause a covered dependent to lose coverage, entitles that dependent to COBRA Continuation Coverage for 36 months from the date of the Event:

(1) The employee dies

(1) The employee legally separates or divorces

(2) The dependent child ceases to be eligible as a dependent

(3) Employee's Entitlement to Medicare. (Medicare entitlement is an original Qualifying Event in a limited number of circumstances. A retiree plan with a Medicare entitlement loss of coverage provision would be an example of when Medicare Entitlement would be considered an original Qualifying Event for the spouse and or/other dependents of the retiree

6. Secondary Qualifying Event

a. A Secondary Qualifying Event means another Qualifying Event occurring during the initial 18 months of COBRA Continuation Coverage.

b. A Secondary Event allows a Qualified Beneficiary (other than the employee) who has COBRA Continuation Coverage to extend coverage, under certain circumstances, from 18 months to 36 months measured from the original Qualifying Event.

c. A Secondary Event is an employee's termination, layoff, strike, reduction of hours, or leave of absence followed by:

(1) The death of the employee

(2) Divorce or legal separation from the employee

(3) Employee's entitlement to Medicare if such entitlement would cause a loss of coverage under the group health plan

(4) Dependent child ceases to be eligible as a dependent

7. Loss of Coverage in Anticipation of a Qualifying Event

a. If coverage is reduced or eliminated in anticipation of a COBRA Qualifying Event, the reduction or elimination is disregarded for COBRA purposes.

b. Once the employer receives notice of the event, the plan is required to make COBRA available. The COBRA coverage would begin the date of the Qualifying Event. The span of time between the loss of coverage and Qualifying Event does not matter.

c. There is no requirement for the employer to provide coverage in the period between the loss of coverage and the Qualifying Event.

8. Extension of COBRA Continuation Coverage Due to Qualification for Social Security Disability

a. COBRA coverage may be extended from 18 to 29 months for a Qualified Beneficiary, and his/her covered family, who is deemed by the Social Security Administration to have been disabled before the end of the first 60 days of COBRA continuation coverage.

b. If one member of the covered family qualifies for the 29 months, the entire covered family qualifies for the 29 months.

c. Each family member retains Qualified Beneficiary status during the extensions period.

d. If a second Qualifying Event occurs during the extension period, a Qualified Beneficiary (other than the employee) retains the right to an extension of the maximum coverage period to 36 months. (Medicare entitlement is often a Secondary Event during this extension period.)

e. The individual must notify the employer of the Social Security Disability determination before the expiration of the 18 months and within 60 days of the date the disabled individual receives it.

9. The Types of Plans to Which COBRA Applies

a. COBRA applies to a plan maintained by an employer or employee organization to provide health care, whether directly or through insurance reimbursement or otherwise. Health care includes the diagnosis, cure, mitigation, treatment, or prevention of disease, and any other undertaking for the purpose of affecting any structure or function of the body.

b. Dental, vision, prescription drug coverage, mental health coverage, Health FSAs, as well as medical plans must be offered as COBRA coverage at the time of the Qualifying Event or at other times that active employees could add one or more of these plans.

c. Life insurance and group disability insurance are not required to be offered as COBRA coverage.

d. When a Qualifying Event occurs, each Qualified Beneficiary (covered individual) has the opportunity to continue, under COBRA, the group health insurance benefits he/she was receiving immediately before the Qualifying Event.

e. The coverage offered under COBRA cannot differ from the prior coverage and cannot be based on evidence of insurability.

f. How the coverage must be offered to individuals depends on the type of plan the Qualified Beneficiary was covered under immediately prior to the Qualifying Event.

(1) One plan

(a) When the only option available to active employees is a combined Plan including medical, dental, and vision, and the active Employee must take all or none, then

(b) The only option that must be made available to Qualified Beneficiaries is the combined Plan

(2) Separate plans

(a) When benefits are provided under separate Plans, i.e., active employees may select medical only, dental only, medical and vision, etc., then,

(b) A Qualified Beneficiary may elect under COBRA, any or all of the Plans they had before the Qualifying Event, and,

(c) The employee and each of his/her covered Dependents have independent election rights and therefore, may continue different combinations of Plans

10. Flexible Spending Accounts (FSAs)

a. Health FSAs are a group health plan as defined by the Internal Revenue Code (IRC) and therefore are subject to COBRA Continuation Coverage requirements. However, "the IRS and Treasury believe that the purposes of COBRA are not furthered by requiring an employer to offer COBRA…if the amount that the employer could require to be paid for the COBRA coverage for the plan year would exceed the benefit that the Qualified Beneficiary would receive…"

b. Situations in which an employer is required to offer the Health FSA under COBRA are limited. Under the following two-step test, if the health FSA satisfies two conditions it does not need to be offered beyond the Plan year in which the Qualifying Event took place.

(1) Benefits under the Health FSA are excepted benefits under HIPAA, and

(2) The maximum payments for a year of COBRA equals or exceeds the maximum benefit available under the Health FSA

c. The Health FSA does not need to be offered at all if the Health FSA meets the following third test:

(1) The plan passes the above two-step test, and

(2) The Qualified Beneficiary has a zero or over-spent Health FSA account balance

11. Alternative Coverage

    a. Alternative Coverage is coverage provided to a Qualified Beneficiary after a Qualifying Event that is not COBRA coverage. This may be a requirement of a state or local law, a retirement plan, industry practice, a severance agreement, collective bargaining agreement or plan procedure.

    b. If the Alternative Coverage is not as good as or better than the coverage the Qualified Beneficiary had the day before the Qualifying Event, then COBRA must be offered side by side to the Alternative Coverage.

    c. If an event, such as the death or divorce from the covered employee would end the right of a spouse or dependent child to receive the Alternative Coverage, then that event is a Qualifying Event and COBRA must be offered for 36 months from that Event. This is regardless of whether the Event occurs within the initial 18-month period or whether the Alternative Coverage is as good as COBRA.

12. Notifications

    The COBRA law requires employers and/or plan administrators to notify Qualified Beneficiaries of their COBRA rights. Under VEBA, COBRA Notifications are the responsibility of Participating Employers. Enforcement of COBRA Notification provisions falls under the Department of Labor (DOL). The DOL has issued Notification Regulations and included sample Notifications; however, employers must customize their Notices and are responsible to keep them updated. Employers should always mail Notifications—never hand them to the employee or other Qualified Beneficiary.

    a. General Notice

        (1) The purpose of the General Notice is to acquaint employees and other covered Qualified Beneficiaries with the COBRA law, their Notification obligations and their possible rights to COBRA Continuation Coverage in the future.

        (2) Employers/plan administrators were required to provide the General Notice to all covered employees (and spouses) when the plan became subject to COBRA.

        (3) The General Notice must also be sent to all new plan enrollees and their spouses at the time of commencement of coverage under the plan and not later than

(a) ninety days from commencement of coverage, or

(b) ninety days from the date the plan was required to comply with COBRA, or

(c) the first date on which the employer/plan administrator is required to furnish the notice of the Qualifying Event

(4) When a Qualifying Event occurs within the first 90 days of coverage, the Qualifying Event Election Notice will satisfy the General Notice requirement if it is sent by the 90th day.

(5) The General Notice should be sent first class mail to both enrollee and spouse at last known address. If all covered family members reside at the same address, a single notice will suffice. Notification to the spouse is deemed notification to all individuals residing with the spouse.

b. Notice from the Qualified Beneficiary to Plan Administrator

(1) The Regulations require the covered employee or other Qualified Beneficiary to notify the employer/plan administrator of the following Qualifying Events:

(a) Divorce or legal separation

(b) Dependent child ceases to be a dependent

(c) Secondary event

(d) Deemed to be disabled by Social Security Administration

(e) Within 30 days if deemed no longer disabled by Social Security Administration

(2) The Notice is required to be given within 60 days from the later of:

(a) The Qualifying Event date

(b) The loss of coverage date

(a) The date the Qualified Beneficiary is informed through the Plan's Summery Plan Description or General Notice of both the obligation to report the Event, and the plan's procedures for providing such a Notice.

c. Qualifying Event Election Notice

(1) The purpose of the Qualifying Event Election Notice is to inform each Qualified Beneficiary that they have rights to continue their group health insurance coverage under COBRA.

(2) The Department of Labor has issued some drafting guidelines for the Qualifying Event Election Notice and the Federal courts have expanded upon these requirements; however it remains the employer's responsibility to formulate and generate these notices.

(3) The employer/plan administrator is required to notify all Qualified Beneficiaries of their COBRA rights within 44 days of the date their learn of the Event.

(4) The Qualifying Event Election Notice should be sent first class mail to all Qualified Beneficiaries (for example, employee and spouse) at the last known address. If all Qualified Beneficiaries reside at the same address, a single notice will suffice, as long as it is addressed to include all Qualified Beneficiaries. If a Qualified Beneficiary in a family lives at a different address, a separate Notice needs to be mailed to that Beneficiary at that address. Although not required, some form of documentation of mailing is advisable.

d. Notice of Unavailability

(1) The 2004 Final Regulations require that employers generate a Notice of Unavailability of continuation coverage to provide an explanation as to why a Qualified Beneficiary is not entitled to COBRA continuation coverage.

(2) When applicable, this Notice of Unavailability is sent after the Qualified Beneficiary has informed the employer of the following Events:

(a) Divorce or legal separation

(b) Dependent child ceases to be a dependent

(c) Secondary events

(d) Social Security disability

(3) This Notice must be in writing and must be sent within 44 days from the date of the occurrence.

e. Extension Notice

There are three ways a Qualified Beneficiary can extend his/her COBRA coverage. Although the Extension Notice is not specifically required, the DOL recommends that Employers generate a notice regarding the extension of COBRA coverage. The Extension Notice should inform the Qualified Beneficiary of the new continuation coverage time frame, monthly premium rates (especially in disability cases), premium due date and the reason coverage can be cancelled prior to the end of the maximum coverage period.

(1) The Extension Notice is applicable to:

(a) Secondary Events

(b) Special Medicare Entitlement

(c) Disability Extension

(2) The Extension Notice should be sent when the employer/plan administrator is informed of a COBRA extension.

f. Open Enrollment Notification

COBRA Beneficiaries have the same rights under the Plan as active employees. This includes rights during open enrollment periods. The Open Enrollment Notification should inform COBRA Beneficiaries of the Open Enrollment Period, the options available, and the monthly premium rates for those options. COBRA Beneficiaries include:

(1) Qualified Beneficiaries in their 60-day election period

(2) Qualified Beneficiaries who have elected but have not yet paid

(3) Qualified Beneficiaries who have elected and paid

g. Notification of Plan Changes

The Employee Retirement Income Security Act of l974 (ERISA) requires that plan benefit changes, premium rate changes, and other modifications to the plan be communicated to all plan participants, including COBRA participants. According to the Department of Labor, the notification of plan and/or benefit modifications should be sent to COBRA participants "within 60 days after the change has been adopted by the plan." The IRS regulations state that notification of rate changes must be provided to Qualified Beneficiaries prior to charging them the new rate.

h. Right to Convert Notice

The purpose of the Right to Convert Notice is to advise COBRA participants that their COBRA coverage is coming to an end and they have the right to elect an individual conversion policy if such an option is available under the group health plan. Employers/plan administrators are required to notify all Qualified Beneficiaries of their right to elect a conversion option within 180 days prior to the expiration of their COBRA coverage. The Notice should be sent first class mail to last known address.

i. Notice of Insignificant Premium Underpayment

(1) The 1999 Final Regulations mandate that before a plan can terminate COBRA coverage for an insignificant underpayment (a payment that does not quite total the full monthly premium amount), the plan must provide a notice to the Qualified Beneficiaries. The 2001 Final Regulations state, "a shortfall is not significant if it is no greater than the lesser of $50 or 10 percent of the required amount".

(2) The Notice must inform the Qualified Beneficiaries of the amount of the underpayment and the fact that coverage will terminate if the balance of the payment is not received. The plan must give the Qualified Beneficiaries at least 30 days from the date of the Notice to make the payment. The Notice should be sent first class mail to last known address.

j. Disclosure to Health Care Provider

The purpose of this Disclosure is to more completely inform health care providers of the Qualified Beneficiary's coverage status, so as to avoid situations where services are denied because only partial information was conveyed. The plan is responsible for complete information whenever a health care provider inquires as to a Qualified Beneficiary's coverage status. The plan must inform the health care provider that the Qualified

Beneficiary does not have current coverage, but will have retroactive coverage if COBRA is elected and subsequently paid for by the appropriate dates. It is allowable for a third party to elect COBRA for a Qualified Beneficiary.

k. Notice of Early Termination of Coverage

(1) An employer/plan administrator is required to send a Notice of Early Termination of Coverage to an affected Qualified Beneficiary if his/her coverage will be terminated prior to the 18-, 29-, or 36-month continuation period.

(2) The Notice must be sent as soon as administratively practicable after the termination decision is made and must explain why and when the coverage is being terminated and must describe any right to other coverage that is available.

(3) COBRA Regulations allow plans to include the Notice with the HIPAA Certificate.

13. Election Period and Time Frames

In accordance with COBRA statutes, employers/plan administrators, and Qualified Beneficiaries have specific time frames in which to accomplish certain tasks.

a. Qualifying Events

(1) It is the employer's responsibility for knowing when an employee's voluntary or involuntary termination of employment, reduction of hours, strike, layoff, or leave of absence occurs

(a) The employer/plan administrator has 44 days from the Qualifying Event Date to generate a Qualifying Event Notice to all Qualified Beneficiaries. The Notification is deemed made on the date it is sent. The Notice should be sent first class mail. Documentation of mailing is advisable

(b) To make a timely election to accept COBRA continuation coverage, each Qualified Beneficiary has the later of 60 days from the date of the Qualifying Event or the date the COBRA Qualifying Event Notice is sent by the employer/plan administrator. The election is deemed made on the date it is sent to the employer/plan administrator

(2) For Events such as the employee's divorce, legal separation, a dependent child ceasing to be eligible, Social Security Disability, and Secondary Events:

(a) It is the employee's or other Qualified Beneficiary's responsibility to notify the employer/plan administrator within 60 days from the latter of the Qualifying Event date, the loss of coverage date, the date the Qualified Beneficiary is informed of both the obligation to report the Event and the plan's procedure for providing such notice

(b) If the employee or other Qualified Beneficiary fails to report the Event within the proper time frame, the Qualified Beneficiary loses the right to continuation coverage

b. Retroactive Premium Payment Period

The COBRA law prohibits employers from requiring the payment of any premium before the 45th day (from the election date). The employer may require that all retroactive premiums be due by the 45th day to bring the Qualified Beneficiary current.

c. Prospective (Monthly) Premium Payment Period

For prospective premiums, COBRA participants are allowed a minimum, 30-day grace period each and every month. If the plan allows a grace period longer than 30 days, COBRA participants must also be allowed the longer grace period.

d. Insignificant Underpayment Grace Period

If a Qualified Beneficiary underpays the premium by an insignificant amount, the plan can accept the amount as payment in full or seek the rest of the payment. Before canceling the Qualified Beneficiary's coverage for underpaying by an insignificant amount, the plan must send a notice to the Qualified Beneficiary and give at least a 30-day grace period form the date of the notice to pay the balance of the premium.

14. Incapacitation

According to several courts decisions, when a Qualified Beneficiary becomes incapacitated during or prior to a period of time in which the Qualified Beneficiary must take an action, the affected period of time is suspended until the person is no longer incapacitated, or has an executor appointed (in the event the Qualified Beneficiary dies before becoming no longer incapacitated).

15. Terminating Events

The COBRA law lists specific times when continuation coverage may be terminated. The nine Terminating Events that follow are the only times when an employer may cancel COBRA coverage and be in compliance with the law. Coverage may be cancelled at the earliest of the following:

a. Eighteen months from the Qualifying Event date for individuals whose coverage ended because of a termination or reduction of hours

b. Twenty-nine months from the Qualifying Event date for individuals whose coverage ended because of a termination or reduction of hours, and the continuation coverage was extended to 29 months due to a Qualified Beneficiary's Social Security Disability determination

c. Thirty-six months from the Qualifying Event date for individuals whose coverage ended because of the death of the employee, divorce/legal separation, a dependent child ceasing to be a dependent or the employee's Medicare entitlement

e. Thirty-six months (for spouse and dependent child only) from the date of the employee's Medicare entitlement (where insurance coverage is not lost) that precedes a termination or reduction of hours by 18 months or less

f. The first day for which timely payment is not made to the plan. Timely payment was described in Prospective Premium (IX 12. c. above) and Insignificant Underpayment Grace Period (IX I2. d. above)

g. The date on which the Qualified Beneficiary first becomes, after the date of the election, covered under another group health plan that does not contain any exclusion or limitation with respect to any pre-existing condition of the beneficiary other than an exclusion or limitation which does not apply to, or has been satisfied under the Health Insurance Portability and Accountability Act of 1996 (HIPAA)

h. The date on which the Qualified Beneficiary first becomes, after the date of the election, entitled to Medicare

i. The date the Employer ceases to maintain any group health plan

j. In the case of individuals receiving the 11-month Disability Extension due to a Qualified Beneficiary being deemed disabled by the Social Security Administration, coverage may terminate the first of the month 30 days after the date of the final determination that the Qualified Beneficiary is no longer disabled. The 1999 Proposed Regulations clarify that if a Qualified Beneficiary is deemed no longer disabled, this would terminate the COBRA coverage for all Qualified Beneficiaries who were entitled to the disability extension

k. According to the 1999 Final Regulations, the group health plan can terminate "for cause" the coverage of a Qualified Beneficiary receiving COBRA on the same basis that the plan terminates "for cause" the coverage of a similarly situated non-COBRA beneficiary

16. COBRA Premiums

a. In accordance with COBRA statute, the person paying the COBRA premium has the right to make premium payments in monthly installments. The 1999 Final Regulations state that the plan can allow other options, in addition to monthly payments. Such options might be weekly, quarterly or semi-annual payments.

b. Employers are allowed to charge COBRA participants up to 102 percent of the applicable premium for continuation coverage. According to the COBRA statute, applicable premium means, "the cost to the plan for such period of the coverage for similarly situated Beneficiaries with respect to whom a qualifying event has not occurred (without regard to whether such cost is paid by the employer or employee)".

c. Generally, COBRA premiums cannot be more than 102 percent of the premium for active employees. However, if a Qualified Beneficiary is disabled and continuing his/her coverage under COBRA for 29 months, the employer is allowed to charge the disabled Qualified Beneficiary up to 150 percent of the applicable premium from the 19th to the 29th month. If the disabled individual is part of the coverage, family members may also be charged up to 150 percent if the disabled individual is part of the coverage. If the disabled individual is not part of the coverage then the plan may only charge the usual COBRA rate of up 102 percent.

E. Health Insurance Portability and Accountability Act (HIPAA)

1. Certificate of Coverage

a. Under HIPAA, this Plan is required to furnish a certificate of coverage to Employees and Dependents in the event that coverage ceases. The purpose of this certificate is to provide documentation of prior coverage. HIPAA assumes that the Employee will present the certificate to the ensuing health care plan as evidence of prior coverage; the ensuing plan may also request that the certificate be mailed to it directly. Depending on the circumstances, that plan may waive all or part of any pre-existing coverage exclusions if the certificate is presented to the health plan on a timely basis. A certificate of creditable coverage will be issued to:

(1) An individual, who is entitled to elect COBRA continuation coverage, at a time no later than when a notice is required to be provided for a qualifying event under COBRA

(2) An individual, who loses coverage under a group health plan and who is not entitled to elect COBRA continuation coverage, within a reasonable time after coverage ceases

(3) An individual, who has elected COBRA continuation coverage, either within a reasonable time after the Plan learns that COBRA continuation coverage ceased or, if applicable, within a reasonable time after the individual's grace period for the payment of a COBRA premium ends

b. The certificate will contain information required by law or regulation. The certificate will reflect a maximum of 18 months of creditable coverage not interrupted by a break in coverage of 63 days or more.

c. An individual also may request a certificate within 24 months of losing coverage. That request should be directed to the VEBA Administrator.

d. Issuing Notices

(1) Whenever a participant terminates coverage for any reason, the Employer will issue a certificate of coverage. Some of the events triggering this notice requirement are:

(a) Termination of employment

(b) Change to a non-benefit-eligible position

(c) Termination of COBRA (for any reason)

(d) Termination of subscriber or dependent coverage at annual re-enrollment

(e) Dependent child no longer meets the eligibility definition under the plan

(2) The notice will be issued in the same timeframe that the Employer uses to issue COBRA letters. The Employer will certify the period of continuous coverage ending on the termination date of coverage. "Continuous" means that the coverage period does not have any breaks exceeding 62 calendar days. The names of any Dependents should be included on the form if that information is reasonably available to the employer.

(3) Employers also must issue certificates to individuals who request them within 24 months following their cessation of coverage.

e. Receiving Notices

(1) When an Employee first becomes eligible for benefits, the Employee may present to the Employer a certificate of coverage from prior employment. The Employer will send a copy of the certificate to the VEBA Administrator. The copy will be routed to the insurance carrier for determination of the remaining period for preexisting condition limitations. The insurance carrier will respond to the individual in writing within two weeks if any portion of the six-month preexisting condition period remains. No response from the insurance carrier is required if the entire preexisting period will be offset by the certificate of coverage.

(2) In the event that an Employee or Dependent is not issued a Certificate of Coverage by the prior employer, the Employer may call the other plan and obtain information over the phone. That information can be sent to the VEBA Administrator and will be forwarded to the insurance carrier for review.

2. Special Enrollment Provisions

a. Under HIPAA, an Employee or his or her Dependent(s), who initially declined to enroll in VEBA, must be allowed to enroll during the Plan Year if they meet the below described conditions:

(1) The Employee gains a Dependent through marriage, birth, adoption, or placement for adoption

(2) The Employee, spouse, or other Dependent(s) loses other coverage through another employer (e.g., due to legal separation, divorce, death, termination of employment, reduction in hours, termination of contributions for coverage by the other employer, or completion of the maximum COBRA continuation period)

b. The Employee must make a request to the Employer to exercise this special enrollment option. The Employee must request coverage within 30 days of the event as noted above.

c. Coverage is effective as of the date of the event (i.e., birth, adoption, or placement for adoption), except for marriages. Coverage for a spouse in the event of marriage is effective on the first of the month following the date of the request.

d. Employees otherwise eligible for a VEBA plan who choose to disenroll from another plan do not qualify for this special enrollment option and are treated as late enrollees. As such, the Employee or his or her Dependent may not enroll in the Plan except during the annual Open Enrollment Period (unless he or she qualifies for the special 30-day enrollment period cited earlier).

Section X
Exhibits

Exhibit A
Ten-Tier Rate Structure

Exhibit B
Domestic Partner Documents

Exhibit A

Ten-Tier Rate Structure Effective 01/01/2012

Each of the following charts outlines three questions that, when answered, determine the applicable rate tier for either the HMO or PPO plan.

HMO Rate Tiers

Three Questions	Bargained/Non-Bargained Unit Status	Points
1. For this bargained/non-bargained unit, what % of the family rate in the UHC Performance HMO Network 1 does the district contribution cover (after any mandatory coverages) - assumes that singles and two-party receive at least this %?	96%-100% 87%<96% 78%<87% 69%<78% 61%<69% 53%<61% 45%<53% <45%	7 points 6 points 5 points 4 points 3 points 2 points 1 point 0 points
2. For this bargained/non-bargained unit, are any employees paid cash or given other benefits if they waive all or part of the medical coverage (e.g., waive dependent coverage or waive coverage entirely)?	Yes No	-1 point 1 point
3. Is active employee enrollment for UHC (HMO and PPO combined) at least 45% of those taking medical?	100% in UHC At least 45% but less than 100% Less than 45% in UHC	3 points 2 points 0 point
Total the points (should total from 0 to 11)		
The total points link directly to the rates.		10-11 points Tier X 9 points Tier IX 8 points Tier VIII 7 points Tier VII 6 points Tier VI 5 points Tier V 4 points Tier IV 3 points Tier III 2 points Tier II 0-1 points Tier I

PacifiCare PPO Rate Tiers

Three Questions	Bargained/Non-Bargained Unit Status	Points
1. For this bargained/non-bargained unit, what % of the family rate in the PPO does the district contribution cover (after any mandatory coverages) - assumes that singles and two-party receive at least this %?	96%-100% 87%<96% 78%<87% 69%<78% 61%-69% 53%<61% 45%<53% <45%	7 points 6 points 5 points 4 points 3 points 2 points 1 point 0 points
2. For this bargained/non-bargained unit, are any employees paid cash or given other benefits if they waive all or part of the medical coverage (e.g., waive dependent coverage or waive coverage entirely)?	Yes No	-1 point 1 point
3. Is dependent enrollment (number of 2-party and family compared to the total enrolled in PPO) at least:	60%+ 50%<60%	2 points 1 point
Total the points (should total from 0 to 11)		
The total points link directly to the rates.		10 points Tier X 9 points Tier IX 8 points Tier VIII 7 points Tier VII 6 points Tier VI 5 points Tier V 4 points Tier IV 3 points Tier III 2 points Tier II 0-1 points Tier I

Exhibit B

Health Coverage For Domestic Partners

An Employee may provide coverage for an eligible Domestic Partner and/or the Partner's Eligible Dependent Children by submitting appropriate enrollment forms within required timelines.

Eligibility

VEBA offers Domestic Partner Coverage under either of the following two eligibility provisions:

1. Employees may qualify for Domestic Partner Coverage by having registered the Domestic Partnership with the State of California and providing to the VEBA, a copy of the registration.

2. An Employee who has not registered the Domestic Partnership with the State of California may qualify for Domestic Partner Coverage by meeting the requirements of, and filing, a Declaration of Domestic Partnership with the VEBA.

Possible Tax Implications of Domestic Partner Coverage

1. An Employee who provides Domestic Partner coverage will have added to his/her taxable income for purposes of federal income taxation, the fair market value of the health coverage accorded the Domestic Partner and/or his/her Dependents, (less any contribution paid by the Employee for this coverage) subject to withholding, unless it can be demonstrated that the Domestic Partner and/or his/her Dependents qualify as a Dependent of the Employee for federal income tax purposes.

2. State taxes may apply if the Employee and Domestic Partner fail to register with the state of California or other applicable state where they reside.

3. An Employee may want to consult an attorney concerning any possible income tax implications of providing Domestic Partner coverage.

4. Neither the District nor the Southern California Schools Voluntary Employees Benefits Association or any employee or agent can definitely identify the tax consequences.

Enrollment Process and Timelines

For Domestic Partners **registered with the State of California**, a properly completed enrollment form and copy of the registration endorsed as filed by the California Secretary of state must be submitted to the Employer/Plan Administrator within the following required timelines:

1. 31 days of the date of hire, or

2. for a continuing Employee newly eligible to enroll for benefits coverage, within 31 days of attaining eligibility, or

3. within 31 days of registration with the State of California, or

4. the Employer's annual Open Enrollment Period; the effective date must coincide with the beginning of the Employer's Plan Year.

An Employee who **has not registered the Domestic Partnership** with the State of California may enroll under this option only during the Employer's Annual Open Enrollment period by submitting the required forms and attachments to the Employer/Plan Administrator. (See the attached Declaration of Domestic Partnership form for requirements.)

Cessation of Domestic Partner Coverage

The Employee and/or the Domestic Partner have a responsibility to notify the Employer/Plan Administrator of the termination of the Domestic Partnership within (30) days of the first to occur of the following:

1. The death of the Domestic Partner

2. The date on which any of the criteria of a Domestic Partnership relationship is no longer met

If the Employee fails to make the required notification, the Employee will be liable for any expenses incurred by the VEBA with respect to the former Domestic Partner or his/her Dependents after the termination of the Partnership and must reimburse the VEBA for the value of those benefits. The VEBA shall have the right to recover attorney fees and costs incurred in collecting such expenses from the Employee**.**

Coverage for a Domestic Partner and his/her Eligible Dependent Children will cease on the first to occur of the following:

1. The end of the month in which the death of the Domestic Partner occurs

2. The end of the month in which one or more of the criteria of Domestic Partnership is no longer met

3. The end of the month for which a required Employee contribution is made for coverage for a Domestic Partner or his/her Dependents

Under current law, a Domestic Partner and his/her Dependents are not eligible for COBRA continuation coverage upon cessation of VEBA coverage; however a limited conversion plan may be available through the medical plan carrier.

Declaration of Domestic Partnership

I,_____, submit this Declaration of Domestic Partnership to establish
(Name of Employee)

_____as my Domestic Partner (as this term is defined
(Name of Domestic Partner)

below) for the purpose of qualifying for any benefits that the District may extend to employees in a Domestic Partnership.

I,_____, declare and acknowledge as follows:
(Name of Employee)

I and_____are Domestic Partners.
(Domestic Partner)

"Domestic Partners" means two adults of the same or opposite sex who have chosen to share their lives in an intimate and committed relationship, reside together, and share a mutual obligation of support for the basic necessities of life.

Specifically, I declare and acknowledge that I and my Domestic Partner named above meet all of the following criteria:

- Are both at least 18 years old, and
- are not legally married to anyone, and
- have had at least twelve complete months between the date of the termination of any prior marital status or domestic partner relationship and the date the domestic partner application is submitted, and
- reside in the same residence, with the intent to reside together permanently, and
- have the mental competence to contract, and are not related by blood to the degree that would bar marriage under California law, and
- have resided together continuously for the twelve complete months preceding application for coverage, and
- have agreed to be jointly responsible for basic living expenses, including food, shelter, and other expenses of the joint household, and
- have terminated any prior domestic partnership at least twelve complete months prior to application for coverage, and
- have filed a fully complete application, together with attachments.

This Application must be accompanied by any one of the following to establish joint residence:

- Copies of driver's licenses for both individuals which contain the same address, or
- Mortgage documents or deed containing the names of both individuals, or
- Rental lease agreement containing the names of both individuals.

This Application must be accompanied by any one of the following to establish financial interdependence:

- Joint checking or savings account, or
- Credit cards with the same account number in both names, or
- Common ownership of real property or a common leasehold interest in real property, or
- Common ownership in a motor vehicle, or
- Joint wills in which one partner is the primary beneficiary under the other partner's will, or
- Designation of both partners as authorized signatories on safe deposit boxes, or
- Designation of the Domestic Partner as the beneficiary under the Employee's life insurance plan.

I acknowledge that:

- I cannot file another Declaration of Domestic Partnership for a new Domestic Partnership until at least twelve months after a Statement of Termination of Domestic Partnership has been filed.
- If requested, I will provide to the District's Plan Administrator or designated representative documents establishing the existence of my Domestic Partnership relationship.
- Neither the District nor the Southern California Schools Voluntary Employees Benefits Association is providing legal advice and that I have been advised to consult an attorney regarding the possible legal implications of filing this Declaration of Domestic Partnership.
- I have an obligation to file a Statement of Disenrollment, Death, or Termination of Domestic Partnership with the District's Plan Administrator or designated representative within [30] days of the earliest of (a) the death of my Domestic Partner; (b) the date on which any of the criteria of a Domestic Partnership relationship is no longer met. I further understand that the effective date of the end of the Domestic Partnership relationship is the earliest of (a) the death of my Domestic Partner; (b) the date on which I file a Statement of Disenrollment, Death or Termination of Domestic Partnership with the District's Plan Administrator or designated representative; (c) the date on which the Domestic Partner notifies the Plan of the termination of the Domestic Partnership; (d) the date on which one or more of the criteria of Domestic Partnership are no longer met.
- I understand that I am responsible for the reimbursement of any expenses incurred as a result of any false or misleading statement contained in this Declaration of Domestic Partnership, including claims paid under any benefit plans in which I enroll my Domestic Partner and/or child(ren) of a Domestic Partner. The Plan shall have the right to recover attorney fees and costs incurred in collecting such expenses from me.

I declare, under penalty of perjury, that the foregoing is true and correct that this Declaration was executed on_____at_____, California.

Dated:_____ _____
(Signature)

_____
(Name of Employee)

_____
(Address)

_____
(City, State, ZIP Code)

_____
(Name of Domestic Partner)

Domestic Partner
Health Care Enrollment Statement

To enroll_____, and/or his or her eligible dependent

(Name of Domestic Partner)

children, if any, in the District's group health care coverage that, subject to certain limitations, covers District employees and their Domestic Partners, I declare and acknowledge my understanding that:

- The options under the group health coverage currently available to employees who choose to enroll their Domestic Partners and/or child(ren) of Domestic Partners may be more limited than those available to other employees (i.e., limited to medical, dental, and vision coverage only).

- All group health coverage is governed by the terms of the underlying plan(s) ("Plan").

- If I choose to enroll only the child(ren) of my Domestic Partner, I understand that my Domestic Partner may not subsequently enroll in the group coverage until a future District annual enrollment period.

- The effective date of coverage may only coincide with the District's annual health care re-enrollment date next following the timely receipt of my signed election.

- Unless my Domestic Partner and/or child(ren) of my Domestic Partner also are considered my dependent for tax purposes under Section 152 of the Internal Revenue Code, the Internal Revenue Service currently treats as imputed income to the employee the value of the health coverage provided the Domestic Partner's dependents, if any, less any contribution paid by the employee for this coverage. I reviewed the examples of imputed income amounts for group health coverage detailed in the cover letter to this Statement.

  I understand that I should consult an attorney concerning the income tax implications of filing this Statement and that neither the District, the Southern California Schools Voluntary Employees Benefits Association nor any employee or agent can definitely identify the tax consequences.

- I have an obligation to file a statement of Disenrollment, Death or Termination of Domestic Partnership with the District's Plan Administrator or designated representative within [30] days of the earliest of (a) the death of my Domestic Partner, or (b) the date on which any of the criteria of a Domestic Partner relationship is no longer met.

- Regardless of whether the requisite Statement of Disenrollment, Death or Termination of Domestic Partnership has been filed, the effective date of the end of the Domestic Partner relationship, and, therefore, the date on which coverage of my Domestic Partner and his or her dependent children, if any, will end, according to the terms of the Plan, is the earliest of:

  — the date on which my Domestic Partner dies;
  — the date on which my Domestic Partner and I terminate our Domestic Partnership;
  ___ the date on which one or more of the criteria of Domestic Partnership are no longer met; or
  ___ the date on which I file a Statement of Disenrollment, Death, or Termination of Domestic Partner with the District's Plan Administrator or designated representative.

I affirm that the statements in this Statement are true to the best of my knowledge.

DATED:_____

_____
(Signature)

_____
(Name of Employee)

_____
(Address)

_____
(City, State, ZIP Code)

Statement of Disenrollment, Death, or Termination of Domestic Partnership

_____, makes and files this Statement of Disenrollment, Death or
(Name of Employee)

Termination of Domestic Partnership in order to cancel the Declaration of Domestic Partnership previously filed.

I wish to cancel, effective immediately, the Declaration of Domestic Partnership previously filed with respect to_____.
(Name of Domestic Partner)

-OR-

The Domestic Partner relationship between me and_____.
(Name of Domestic Partner)
ended on_____.
(Date of Termination)

-OR-

My Domestic Partner,_____, died on_____.
(Name of Domestic Partner) (Date of Death)

For Termination of Group Health Coverage of Domestic Partnership

I understand that, if my Domestic Partner has previously been covered by the District's group health coverage, the effect of filing this Statement of Disenrollment, Death or Termination of Domestic Partnership is that my Domestic Partner, and/or his or her eligible dependent children, if any, will no longer be covered by the District's group health coverage, in accordance with the terms of the underlying plan(s) ("Plan").

I further acknowledge that it is my responsibility to mail a copy of this signed statement to my Domestic Partner/former Domestic Partner, named above.

I affirm that the statements in this Statement are true to the best of my knowledge.

DATED _____

_____
(Signature)

_____
(Name of Employee)

_____
(Address)

_____
(City, State, Zip Code)