Fundamentals of Cobra, Key points of the Enrollment Form Acknowledgements, Satellite Offices, Employee Benefits Bureau Staff Intro., HR Reminders, and Special Announcements, Local Public Body Transmittal Form, and LPB-Premium Statements

COBRA Administration

Employers who have 20 or more employees, and offer health coverage to those employees, are required to offer a continuation of coverage to those employees and their dependents under the Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA) based on Qualifying Events. Please refer to the COBRA Administration Section of the General Services Department Administrative Guide for a list qualifying events, forms and additional requirements.

Erisa's COBRA Unit provides the following services to assist participants who lose eligibility to participate in the State of New Mexico's benefits program

- Notify qualified beneficiaries about their right to continue coverage.
- Calculate premium billings and notify the Administrative Services Division of the NM State General Services Department, who will send out monthly invoices to COBRA participants former employees.
- Follow up on individuals who are late with premium payments and terminate individuals as appropriate.
- Monitor the expiration date of coverage and terminate individuals at the end of their continuation period (maximum of 18 months).
- Notify participants turning 65 that COBRA coverage will cease the first of the month upon attaining age 65. At this time, all eligible dependents will be informed that they may continue up to a 36-month maximum.
- Respond to questions from participating employees or dependents about the status of their coverage.

BASICS OF COBRA AND COMPLIANCE

- The HR Representative must notify every employee and every covered dependent of all their rights under COBRA when they first become covered under the group plan. Separate notices must be sent if separate residences are maintained. This applies to all current and future employees and covered dependents.
- Each time a qualifying event occurs, Erisa must notify, within 14 days of receipt of notice of the qualifying event, each qualified beneficiary of his or her continuation rights, benefits and premium rates applicable to the plan (s) for which they are eligible.
- For each kind of notification, good faith compliance has been defined as first class mail, addressed to the employee and covered dependents, sent to the last known home address. If the dependent lives at a separate address, separate notifications must be sent.

WHAT IS A COBRA QUALIFYING EVENT?

A qualifying event is any of the following events which would cause a loss of coverage by a qualifying beneficiary under the plan:

1. Termination (other than for gross misconduct) of the employee's employment, for any reason (layoff, resignation, retirement, etc.)

2. Reduction of hours worked by an employee

3. Survivors upon death of the employee

4. Divorce or legal separation

5. Dependent child ceasing to meet eligibility requirements

6. Coverage lost because the active employee elects to make an alternate primary coverage, thus becoming ineligible under the State plan

WHO IS A PREQUALIFIED BENEFICIARY?

COBRA POLICY:

- A pre-qualified COBRA beneficiary is any employee, or covered dependent, who was covered on the date before the qualifying event and would lose coverage under the plan, at any time, because of the qualifying event.

- Domestic Partners and the dependent children of Domestic Partners will be eligible for COBRA if they experience a qualifying event the same as an employee.

Length of COBRA Continuation Coverage

The chart summarizes the length of continuation coverage to which an employee or dependent is entitled as a qualified beneficiary.

Qualified Beneficiary	Length of Coverage	Initial Qualifying Event
The employee and their dependents including newborns and adopted children	• 18 months from the date of the qualifying event • an additional 11 months if you become disabled within the first 60 days of the qualifying event	• reduction in work hours • termination of employment
Dependents including newborns and adopted children.	• 36 months from the date of the qualifying event	• divorce or legal separation • child's loss of dependent status • entitlement to Medicare • death
The employee and their dependents	• an additional 11 months, or a total of 29 months from the date of the qualifying event which started the COBRA continuation coverage	• if before or within 60 days of the initial COBRA continuation coverage, the employee (or their dependent) become disabled, coverage may be extended for 11 months
Dependents	• an additional 18 months or a total of as many as 36 months from the date of the first qualifying event	• if the dependent has already elected 18 months of COBRA coverage and experiences a second qualifying event, coverage may be extended to 36 months from the first qualifying event

HOW TO COMPLETE THE COBRA NOTIFICATION FORM

Used for State, LPB's and Domestic Partner set-up

- The COBRA notification form **must be submitted by HR Reps to Erisa** when loss of any benefit coverage occurs.
- This includes life and disability. The purpose of this form is to remove the employee/dependent from active benefits AND to alert Erisa's COBRA Unit to issue the initial COBRA enrollment packet.
- If the information is not complete, Erisa will return the form to the HR Representative who sent the COBRA initial notification.
- Please fill out form COMPLETELY, making sure to indicate Social Security Number, Name and Date of Birth for **each** individual. Make sure a complete address is provided.
- Indicate *COBRA Effective Date* (month, date, year) that COBRA coverage will begin.
- The effective date is the day after the person is terminated from the State's plan.
- Indicate *level of coverage* (E= Employee Only, S = Employee plus Spouse, C = Employee + Child/ Children, F = Family Coverage).

COBRA NOTIFICATION FORM

- **Note: Dependents information should include date of birth, social security number, address, event, original effective date and termination date. Do not complete the "Hire Date" for dependents.**

COBRA NOTIFICATION FORM

STATE OF NEW MEXICO
COBRA Notification Form

Client Name: State of New Mexico
State Agency/LPB Code: _____
Group Rep Name: _____
Group Rep Telephone #: _____
Date Submitted: _____

Email To: SONM@easitpa.com

please complete one form per employee

SS #	Name	Complete Address City, State & Zip Code	Date of Birth

Cobra Eff. Date	*Level	**Qualifying Event	Plan #	Date of Hire	Orig Eff. Date of Coverage	Term Date of Coverage

***Level:** E=Employee, S=Employee plus spouse, F=Family, C=Employee plus child/children

Plan Number: #1=BCBS PPO, #2=PRES HMO, #3=BCBS HMO, #4=Delta Dental, #5=Vision Service Plan, #6=Employee Supplemental Life, #7=Dependent/Spouse/DP Life, #8=Dependent Child

****Event Code:** 1=Reduction in Work Hours 4=Voluntary Termination 7=Retirement
2=Termination of Employment 5=Legal Separation or Divorce
3=Death of Employee 6=Social Security Disability

Reason For Termination:

_____

Key Points of the Enrollment Form Acknowledgement's

Before you submit your enrollment information you must acknowledge the following by checking each box

Benefits Enrollment

- [ ] I hereby authorize and direct my employer to reduce my salary in the amount necessary to pay for the coverage shown above in accordance with the State of New Mexico Cafeteria Plan, Section 125. Such reductions, considered as elective contributions under the plan, shall commence within the payroll cycle in which this election is received by my payroll center. I understand those deductions shall be taken from my earnings on a pre-tax basis unless I submit the required Premium Only Plan (POP) Waiver Form.
- [ ] Any person who knowingly and with intent to defraud any insurance company or other person files a statement containing any materially false information, or conceals, for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act which is a crime, Insurance Fraud will be prosecuted to the fullest extent of the law and will prohibit access to RMD Benefits in the future.
- [ ] I have had the opportunity to ask questions about my benefit options and my enrollment elections reflect my informed decisions.
- [ ] I understand that once I submit my enrollment information, electing or waiving coverage during the On-line Enrollment Period, I will have limited opportunities to change what I've submitted. Any change must be performed during the Enrollment Period. All other changes outside of the enrollment period during Annual Open/Switch Enrollment will required a qualifying event; e.g., marriage, divorces, birth, death, job status change, etc.

Key Points of the Enrollment Form Acknowledgement's Cont….

- ☐ I reviewed the information I provided in this enrollment before submitting and I confirm that the information accurately reflects my elections.
- ☐ I understand that services will be available subject to exclusions, limitations, and conditions described in the summary plan descriptions (found on each carrier's website). I authorize any hospital, physician, dentist, or other health care provider to furnish, medical information regarding me and my dependents necessary to process claims.
- ☐ The State's Group Benefits Plan is required by Federal Law to maintain and protect the privacy of your health information and provide you with notice of its legal duties and privacy practices. The privacy notice is posted at https://www.mybenefitsnm.com/Documents/HIPAA_Privacy_Notice.PDF on the mybenefitsnm.com website. If you have any questions regarding this notice or the privacy of your health information, please contact RMD at PO Box 6850, Santa Fe, NM 87502, or by telephone at 505-827-2036.
- ☐ I understand that it is my responsibility to ensure the proper deductions are being taken. If deductions are not accurate, I am to contact Erisa at 1-855-618-1800 immediately.
- ☐ I understand that if I am adding any dependents, not previously covered, to my benefits I must submit (Fax: 505-244-6009 or email: SONM@easitpa.com supporting documentation (Proof of Dependency) with my enrollment form, and that my enrollment is not complete until those records have been received by Erisa. Note: Confirmation can be made by calling 1-855-618-1800.

Key Points of the Enrollment Form Acknowledgement's

Disability

- [ ] I understand that in order to be eligible for the disability benefit I must pay 12 consecutive months premiums before I am eligible to submit a claim.
- [ ] I understand by enrolling into this program, it is my responsibility to access the policy at https://www.mybenefitsnm.com/Documents/Disability_Policy.pdf , read it and understand what is required of me while covered under this program
- [ ] I understand I can call Erisa at 1-855-618-1800 with questions regarding this program.

Key Points of the Enrollment Form Acknowledgement's

Health Care And/Or Dependent Care Flexible Spending Benefits

- ☐ I hereby authorize and direct my employer to reduce my salary in the amount necessary to pay for the coverage shown above in accordance with the State of New Mexico Flexible Spending Plan, Section 125. Such reductions, considered as elective contributions under the plan, shall commence within the payroll cycle in which this election is received by my payroll center.
- ☐ I understand that elected Flexible Spending benefits can only be modified or revoked if I undergo a Qualifying Event; e.g., marriage, divorce, birth, death or change in job status.
- ☐ I understand that after the Grace Period for Health Care (March 15 of the following year), any unused money may not be refunded, nor may it be carried over to the following benefit plan year in accordance with current plan provisions and tax laws. (https://www.nmflex.com)
- ☐ I understand, I must submit documentation to validate claims and/or debit card charges. I certify that I will only submit claims for reimbursement under the Flexible Spending Account for eligible expenses incurred by myself and/or eligible dependents in accordance with the terms of the Flexible Spending Plan. (https://www.nmflex.com)

Key Points of the Enrollment Form Acknowledgement's

Flexible Spending Account Transit/Commuter Enrollment

- ☐ I hereby authorize and direct my employer to reduce my salary in the amount necessary to pay for the coverage shown above in accordance with the State of New Mexico Flexible Spending Plan, Section 125. Such reductions, considered as elective contributions under the plan, shall commence within the payroll cycle in which this election is received by my payroll center.
- ☐ I understand that if I chose to revoke my participation in the plan it cannot be effective during the current pay period, it must be for a following pay period.
- ☐ I understand that any unused money for the current benefit plan year may not be refunded; however, the unused monies may be carried over to following benefit plan year as long as the amount expended doesn't exceed annual limits. I also understand that if I terminate employment, any unused monies is forfeited.
- ☐ I understand, I must submit a claim and/or documentation for out-of-pocket Qualified Transportation expenses before I can be reimbursed. I further certify that I will only submit claims for reimbursements under the qualified Transportation benefit plan for eligible expenses incurred by myself, in accordance with the terms of the Qualified Transportation benefit plan. Information regarding the FSA Commuter: Transportation/Parking Program can be found at https://www.nmflex.com/Transit.aspx

URGENT
Agencies with Satellite Offices

- **Primary Contact**
- **Mailing and Physical Address**
- **Phone Number**
- **Number of Employees + an additional 30 for supply cabinet**
- **Cynthia.Maestas@state.nm.us**

- **Deadline: Close of business TODAY**

Employee Benefits Bureau Staff

Amber Espinosa-Trujillo: Bureau Chief

- Appeals
- Request's for Proposals/Contracts
- Budget
- Oversight

Cyndi Maestas: Benefits Bureau Manager

- Daily Operations
- Implementation of new vendors and programs
- Contracts
- Oversight

Employee Benefits Bureau Staff

Katherine Chavez-Compensation & Benefits Analyst

- **Eligibility of Benefits**
- **Monitoring timely premium payments/Deductions**
- **HR-Meeting Webinars**

Reina Espinoza-Compensation & Benefits Analyst

- **Quality Assurance**
- **Yearly scheduled projects**
- **HR Meeting -Webinars**

Employee Benefits Bureau Staff

Carmella Jasso-Management Analyst

- Marketing & Communication
- Data Analysis Management
- Wellness Program

Crystal Lawrence-Benefits Analyst

- Self Pay Premium Payments
- Quality Assurance
- Carriers-Accounts Payable

New Director

Mark Tyndall

HR REMINDERS

- New to the Team:

1. Agency Code
2. Agency Name
3. HR Name
4. Physical Address
5. Mailing Address
5. Phone
6. Fax
7. E-mail

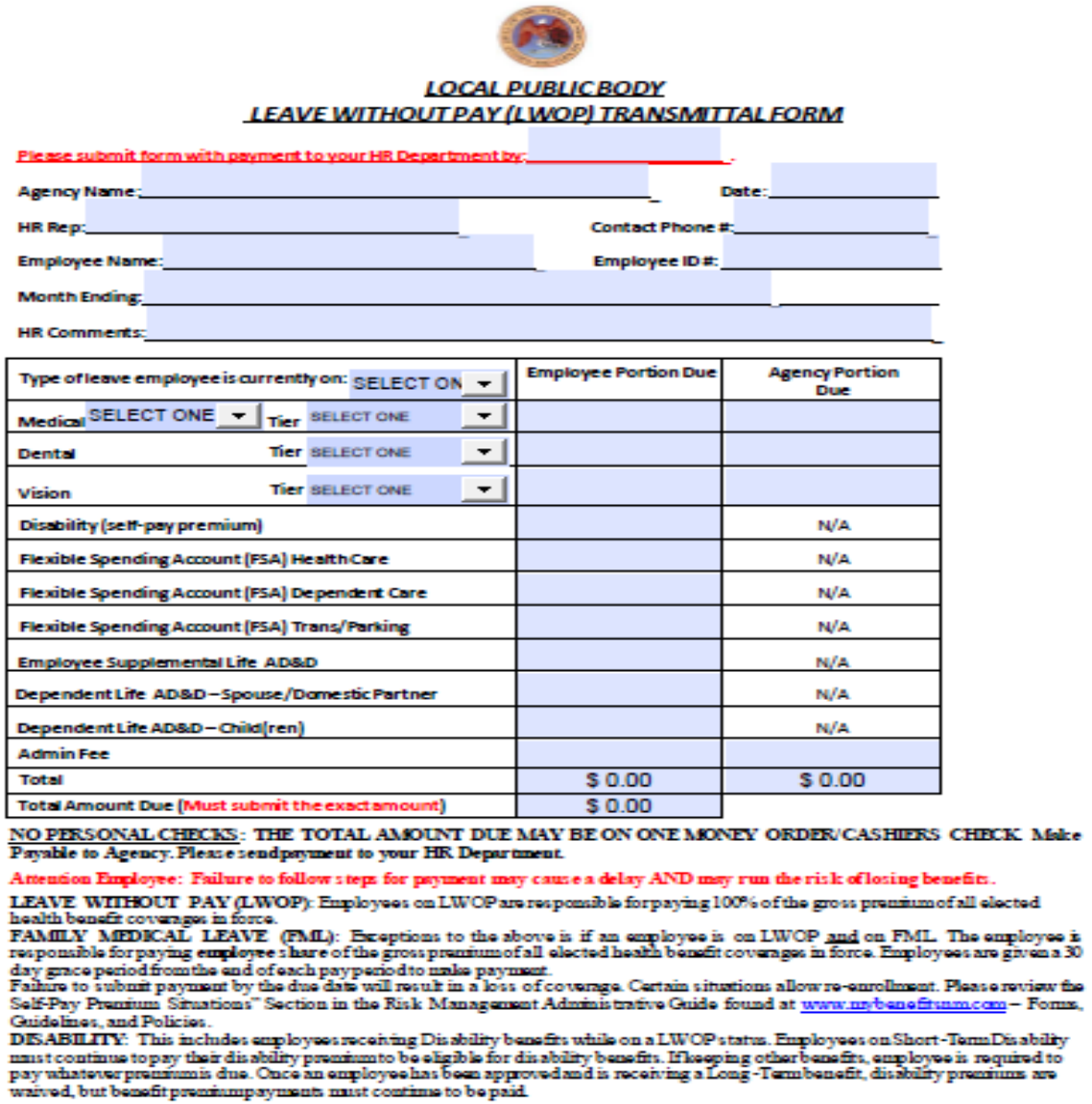
Inform us if this person is replacing an existing HR

Katherine.Chavez2@state.nm.us

Special Announcement:

- Brief explanation of benefits
- How to Enroll Online
- Supporting documentation required
- Acknowledgements

Local Public Body: Transmittal Form



LOCAL PUBLIC BODY
LEAVE WITHOUT PAY (LWOP) TRANSMITTAL FORM

Please submit form with payment to your HR Department by: _____

Agency Name: _____ Date: _____

HR Rep: _____ Contact Phone #: _____

Employee Name: _____ Employee ID #: _____

Month Ending: _____

HR Comments: _____

Type of leave employee is currently on: SELECT ON	Employee Portion Due	Agency Portion Due
Medical SELECT ONE Tier SELECT ONE		
Dental Tier SELECT ONE		
Vision Tier SELECT ONE		
Disability (self-pay premium)		N/A
Flexible Spending Account (FSA) Health Care		N/A
Flexible Spending Account (FSA) Dependent Care		N/A
Flexible Spending Account (FSA) Trans/Parking		N/A
Employee Supplemental Life AD&D		N/A
Dependent Life AD&D – Spouse/Domestic Partner		N/A
Dependent Life AD&D – Child(ren)		N/A
Admin Fee		
Total	$ 0.00	$ 0.00
Total Amount Due (Must submit the exact amount)	$ 0.00	

NO PERSONAL CHECKS: THE TOTAL AMOUNT DUE MAY BE ON ONE MONEY ORDER/CASHIERS CHECK. Make Payable to Agency. Please send payment to your HR Department.

Attention Employee: Failure to follow steps for payment may cause a delay AND may run the risk of losing benefits.

LEAVE WITHOUT PAY (LWOP): Employees on LWOP are responsible for paying 100% of the gross premium of all elected health benefit coverages in force.

FAMILY MEDICAL LEAVE (FML): Exceptions to the above is if an employee is on LWOP and on FML. The employee is responsible for paying employee's share of the gross premium of all elected health benefit coverages in force. Employees are given a 30 day grace period from the end of each pay period to make payment.
Failure to submit payment by the due date will result in a loss of coverage. Certain situations allow re-enrollment. Please review the Self-Pay Premium Situations" Section in the Risk Management Administrative Guide found at www.mybenefitsnm.com – Forms, Guidelines, and Policies.

DISABILITY: This includes employees receiving Disability benefits while on a LWOP status. Employees on Short-Term Disability must continue to pay their disability premium to be eligible for disability benefits. If keeping other benefits, employee is required to pay whatever premium is due. Once an employee has been approved and is receiving a Long-Term benefit, disability premiums are waived, but benefit premium payments must continue to be paid.

- Bill Employee
- Agency Demographics
- Employee Biographics
- Important Dates
- Leave
- Benefits Identification and Amount
  - Omit: FSA if your agency does not participate
- Payment Method
- Employee Reminder: Payment
- Quick Tips
- https://www.mybenefitsnm.com/FGP.htm

PREMIUM STATEMENTS FOR LOCAL PUBLIC BODIES (LPBS)

- Monthly premium statements for all LPBs will be prepared by Erisa and sent electronically by the Administrative Services Division (ASD) of the NM State General Services Department.

- When submitting monthly premium payments, based on Sun Systems-generated invoices, each LPB must submit:

  Two payment checks: one check is for the combined total of all Life coverage premiums, and the second check is for the combined total of all other benefits (medical, dental, vision, disability).

PREMIUM STATEMENTS FOR LOCAL PUBLIC BODIES (LPBS)

- Processes must be followed and payment received as instructed on the electronic invoices. The invoice received from ASD must accompany the remittance check(s).

- PLEASE NOTE: Late payments will be assessed a late penalty fee.

- Erisa, the State's Group Benefits Plan administrator, periodically conducts audits to ensure accurate data on LPB participants, including exact benefit coverages. Due to the importance of maintaining current benefit details, LPBs must return to Erisa the requested audit information within two (2) weeks of receipt.

Suggestions: Reina.Espinoza@state.nm.us

THANK YOU FOR ATTENDING

RESOURCES

- https://www.mybenefitsnm.com/COBRA.htm
- https://www.mybenefitsnm.com/FGP.htm
- https://www.mybenefitsnm.com/Enrollment.htm