Purpose

The purpose of the PRISMHealth Administrative Guidelines is to provide clear, consistent and effective guidance to program members and service providers participating in the PRISMHealth Program. This guidance seeks to educate members on the administrative process as it pertains to eligibility, retroactivity and some claims administration. The intent is to preserve the integrity of the Program and each of its participating members benefit plans as well as to protect the rights of covered employees, retirees and their dependents. These guidelines may be amended from time to time to comply with new legislation and applicable regulations.

Program Eligibility and Retro Activity

Qualified subscribers are defined as:

1. Full-time salaried or hourly employees who are actively at work at least 30 hours per week. Employee of the member entity must meet the eligibility requirements within the member entity's guidelines set for employees.
2. A part time employee who is working a minimum of 20 or more hours per week.
3. Variable Hour, Temporary, Seasonal, and others who become eligible based on the ACA Look-back Measurement/Stability Period.
4. COBRA and CalCOBRA participants eligible to elect coverage through COBRA.
5. A retiree who meets the eligibility requirements set by the member entity for retiree benefits (pre and post Medicare), including the retiree's spouse/domestic partner and qualified dependents.
    a. To qualify for PRISM Medicare plans and rates, retiree must be enrolled in Medicare Parts A&B and cannot be actively working.
6. Retired employees who are currently eligible and participating on the plan will be eligible to continue coverage under the Program, if the coverage permits.
    a. Retirees who decline coverage may not enroll in any coverage at a subsequent enrollment date.
    b. **Note:** If a retiree continues coverage and at open enrollment decides to drop coverage for dependents, the retiree has the same rights as an active employee to add dependents back onto the plan at a future open enrollment or as a result of a mid-year qualifying life event that would normally allow the dependent addition. Adversely, the same does not hold true for the retiree. If a retiree terminates their coverage as the qualified subscriber, the retiree and their dependents will not be allowed the opportunity to re-join the Program since the retiree can no longer be classified as a qualified subscriber.
7. A surviving Spouse of an employee or retiree who is able to continue lifetime coverage as a subscriber.
    a. Spouse in this circumstance should be enrolled under the Early Retiree or the Medicare plan since they are not an active employee. This does not refer to situations where COBRA is offered to Surviving spouses – this instead is extended coverage with no termination date defined.

8. Board members, Trustees, Council members, or other elected officials: Directors, board members, and other elected/appointed officials can only elect plan if they are eligible on the current plan and are subject to the same requirements as Active employees. Exceptions can be made at the recommendation of Alliant Underwriting and with the approval of the PRISMHealth Committee.

Qualified Dependents (Up to age 26)

Qualified Dependents are defined as:

a. Natural Child(ren)
b. Adopted Child(ren)
c. Step Child(ren)
d. Court-Ordered Dependent (Legal Guardian)
e. Child(ren) of a California State Registered Domestic Partner
f. Other Qualified Dependent(s) of a Registered Domestic Partner
g. Spouse
h. Registered Domestic Partner
i. Permanently disabled dependents as defined by the IRS
j. Others not included above that are claimed for tax purposes, must be approved by PRISM staff

Overage-Dependent: Once a dependent turns 26, they are considered an over-age dependent. Over-age dependents will be termed off the respective member plan the first of the month following their birth month.

Qualified disabled dependents will be allowed to remain on the plan. Disabled Dependents do not have to go through medical review until age 26. Once they are age 26 annual medical review is required. There is no coverage age limit for medically approved disabled dependents.

Non-Qualified Dependents fall outside of the definitions above. Common examples of Non-Qualified Dependents are listed below:

a) Grandchild(ren)
b) Parent(s)
c) Grandparent(s)
d) Niece/Nephew/Sibling
e) Foster child(ren) – Non-Qualified as they are covered by the State Government
f) Legally Separated Spouse/Domestic Partner
g) Divorced Spouse – Including employees who are required to cover their former spouse based on a court order. The liability is not on the member entity or the Program, the member must find a plan outside of the group plan to cover the
    a. Ex-spouse
h) Financial dependents that are not court ordered

Domestic Partners

PRISM allows Domestic Partner coverage. The California Family Code defines a domestic partnership as:

1. Two adults of the same sex or opposite sex who have chosen to share one another's lives in an intimate and committed relationship of mutual caring; and
2. The partners are:
    a. Not currently married to someone else or a member of another domestic partnership, and
    b. Not so closely related by blood that legal marriage or registered domestic partnership would otherwise be prohibited; and
3. Both partners are capable of consenting to the domestic partnership; and
4. Both partners must file a Declaration of Domestic Partnership with the California Secretary of State, pursuant to the California Family Code

Unless otherwise specified, Domestic Partners must be California State Registered Domestic Partners.

Mid-Year Qualifying Events

Mid-Year Qualifying Events refers to both the addition and termination of employee and dependent coverage. Under the section 125 rules, an employee can make an election change when they experience a "change in status", which includes events such as marriage, birth of a child, change in employment status, dependents aging out of the plan, HIPAA special enrollment events, and residence change. In addition, section 125 allows election changes under a host of other circumstances, including cost and coverage changes, entitlement to Medicare, Medicaid, Medi-Cal and change in coverage under another employer plan. The change the employee wants to make always has to be consistent with the event that occurred that gives rise to the change.

Nearly all plan changes resulting from Mid-Year Qualifying Events will be effective on the first of the month following the event. Birth and death are exceptions where coverage may be added/dropped on the event date rather than waiting for the first of the month following. All Mid-Year Qualifying Events will follow HIPAA guidelines – which allows employees up to 31 days to report the event to their employer. If any member does not have a copy of the approved Mid-Year Qualifying Events through HIPAA, please contact PRISM to obtain a soft copy. If a change is not reported timely, the employee/retiree will be required to wait until the next open enrollment period to make the change. (Exceptions to terminate due to death are made.)

Mid-year qualifying events require proper documentation to make a change, and member entities are responsible for obtaining and reviewing the appropriate documentation. Please refer to the documentation table from Program Guidelines for adding a dependent. Below is a list of examples of what would be needed for the most common mid-year events:

- Marriage - Marriage Certificate
- Divorce, Legal Separation – Court Documents
- Loss of other group coverage – Loss of coverage notice

- Medicare eligibility – Medicare notice
- Death – Death Certificate
- Change in residence impacting plan eligibility – Verification of new address
- Judgements or decree by court – Court documents

This list is not exhaustive, for all other qualifying events please check in Program Guidelines, with your Alliant Account team, or with your BenAdmin vendor for a full list of events and required documentation.

Retroactivity and COBRA

Federal COBRA (and State CalCOBRA, applicable to Medical HMO plans only) guidelines will be followed without exception. If any member does not have the COBRA guidelines, they may reach out to their Alliant Service Team or PRISM who will provide a soft copy of the manual. The Program makes available COBRA administrative services for all PRISMHealth Program member entities. If a member decides to self-administer COBRA coverage, the member must acknowledge in writing their understanding of the potential liability inherent with self-administering COBRA.

Retroactivity (other than COBRA)

- Members may retroactively make changes (additions/terms) within 60 days of the effective date of the requested change.
- If a request to make a change is between 61 to 90 days from the effective date of change the request will require PRISM staff approval before processing. If claims are incurred and the amount is less than $1,000, the retro request (if deemed reasonable) will be allowed. If claims incurred are greater than $1,000, the 60 day standard retroactivity process will apply.
- Retroactivity requests beyond 90 days will not be allowed unless circumstances determine a processing error on the part of the carrier or vendor. Member and/or subscriber failure to process additions and terms in a timely manner will not be considered for an exception unless extenuating circumstance prevails. These requests will be reviewed by PRISM staff in conjunction with the member entity. Unless an exception is granted, revert to the timelines and processes outlined in the two bullets above.

Rescission of Coverage:

Regulations define “Rescission” for purposes of the ACA’s prohibition as a cancellation or discontinuance of coverage that has a retroactive effect. Section 2712 of the Public Health Service Act (the “Act”), as added by the Affordable Care Act (“ACA”), generally prohibits group health plans and health insurance issuers offering group insurance coverage from rescinding coverage.

The following three actions do not fall under rescission and therefore are permitted:

1. Termination of coverage that is prospective
2. If the cancellation of coverage is effective retroactively because of a failure to timely pay required premiums or contributions.

   Rescission due to failure to timely pay required premiums applies to COBRA participants & Retirees. Note however, that COBRA itself contains rules about when COBRA premiums are due and how to handle de Minimis shortfalls in premium. Employers should act quickly and not allow more than a 45 day grace period past the premium due date to act on termination. Payments for any services and/or pharmaceutical claims incurred cannot be recouped. Premiums will not be returned to the member entity by the PRISM should the termination effective date be more than 60 days.

3. In cases of fraud or intentional misrepresentation of material fact:

   The plan document must state that the employer has the right to retroactively terminate coverage in these circumstances, and must give written advance notice of the rescission. Notice of Rescission letter template is available upon request.

   - Insurance fraud under this situation would be defined as: A person provides false information, or withholds information to an insurer in order to gain something of value (insurance benefits) that he or she would not have received if he/she had provided full disclosure.
   - An example of misrepresentation: An employee has a divorce but fails to let the employer know within a 60 day window, and continues to cover the ex-spouse. Once the divorce is discovered by the employer, the employer may retroactively cancel the member for misrepresentation. Additionally COBRA would not be afforded to the former spouse due to the failure to notify the employer in a timely manner. At that time a notice of unavailability of continuation of coverage is required to be sent to the member.
   - If claims were assessed during the period that the ineligible member was on the plan and accessing care, the member entity may require the employee or retiree to pay the total amount of claims back to the employer and the added premium cost for the misrepresentation.
   - Payments for any services and/or pharmaceutical claims incurred cannot be recouped.
   - Premiums will not be returned to the member entity by PRISM.

4. The termination or cancellation of coverage is initiated by the individual and the employer/plan sponsor does not, directly or indirectly, take action to influence the individual's decision or otherwise take any adverse action to

retaliate against, interfere with, coerce, intimidate, or threaten the individual. Termination request must still fall within the parameters provided to members to notify employers of qualifying life event.

Notice of "Unavailability of Continuation Coverage" (Required Notice): In the event an administrator receives a notice of a divorce/legal separation or a dependent ceasing to be an eligible dependent under the terms of the group health plan and it is determined that the individual is not entitled to continuation coverage, the administrator shall provide to such individual an explanation as to why the individual is not entitled to elect continuation coverage. This would occur if an employee and/or qualified beneficiary fails to follow the reasonable plan procedures for notification or by not making notice within the required 60 day time period. **The administrator must provide the notice within 14-days of receiving the late notice.**

Example of Permissible Retroactive Terminations

Retroactive termination "in the normal course of business" when the employee pays no premiums. This is an accommodation for the common practice of employers/plans reconciling eligibility lists only once per month. Therefore, if a plan only covers active employees (except as required by COBRA) and an employee pays no premiums for coverage after termination of employment, the retroactive elimination of coverage back to the date of termination of employment, due to delay in administrative recordkeeping, will not be considered a rescission. Please see Exhibit 2 table for parameters to notify JPA.

When rescission is prohibited

All other incidences of retroactive termination that do not fall under what is permitted would be considered prohibited. This would include an administrative error on the part of the Individual, Employer or Third Party Administrator.

Not being in compliance with Rescission often will hinder the ability to release COBRA notices within the mandated timeframes resulting in non-compliance for COBRA notification timelines.

Benefit Substitution and Claims

Benefit substitution occurs when the claims administrator requests that the plan make a substitution in benefits due to an individual's specific medical issue. Such requests are typically generated by the claims administrator's nurse case manager who works on high dollar claims to make sure the best possible care is being provided to the patient. The administrator provides background on the medical condition and what substitution of benefits is being requested and the cost or savings associated with such substitution. The administrator also works with the patient (or their family member) to make sure they understand what the substitution is and how it will affect the patient's benefits. ("Claims administrator" or "administrator" in this context refers only to the Medical and Pharmacy claims administrators only i.e. currently Anthem Blue Cross, Blue Shield of California, Kaiser, Delta Health Systems, or Express Scripts.

Benefit Substitution Approval Guidelines

All benefit substitutions will be disclosed to the PRISMHealth Committee as needed and on an annual basis.

Circumstance	Dollar Amount	Approval Method
Administrator recommends benefit substitution and it costs more than regular benefit	Medical – **under** $10,000 RX – **under** $1,000 per prescription per month	Request submitted with member entity signature and reviewed/approved by PRISM staff
Administrator recommends benefit substitution and it costs more than regular benefit	Medical – **over** $10,000 RX – **over** $1,000 per prescription per month	
Administrator recommends benefit substitution and it costs less than regular benefit	Dollar amount not applicable since change creates plan savings	

Out-of-Network Claims and Referrals

Unless specifically covered under a member entity's contract, out-of-Network claims will be denied unless prior approval is requested and approved by the claims administrator or if the service was provided due to a life-threatening emergency.

Circumstance	Approval Method	Approvers
Administrator's Medical Management team determines that service is Medically Necessary	Exception made	PRISM staff with consent from member entity
Administrator would normally approve under a fully-insured contract	Exception made	PRISM staff with consent from member entity
Patient wants to go out of network and it is not medically necessary	Handle case by case	PRISM Committee

Out-of-Network Emergency Claims

The claims administrator will determine if the claim was a true medical emergency. If the claim is determined to be for a medical emergency, PRISM staff will have authority to pay up to amounts billed for emergency services. Staff will consult with the member to make sure they are in agreement with the payment. PRISM will ask the claims administrator to negotiate with the provider or facility to accept UCR (Usual, Customary, and Reasonable) allowances for claims without balance billing the patient. If payment of UCR allowances is not agreed to, billed charges will be paid (less any applicable copayments, deductibles or co-insurance amounts associated with the plan's benefits that are the patient's responsibility to pay).

For two tiered PPO plans, if a claim is determined to be a non-emergency out-of-network claim, the plan will pay per the out-of-network coverage specified by the member's applicable plan document. If a non-emergency out-of-network claim occurs under an EPO plan (one tiered PPO plan) with no-out of network coverage, the claim will be denied and the patient will be responsible for payment.

Process for Appeal of Emergency Claims

1. Claim is submitted by out-of-network provider or patient to the claims administrator.
2. Claims administrator will pay the claim based upon the plan document for the patient. The patient must submit an appeal to the claims administrator if they feel the claim was not processed correctly.
3. If the claims administrator approves the appeal, the patient sends all necessary paperwork to member who in turn sends it to PRISM staff.
4. Appeal received by PRISM staff and verified with claims administrator.
5. If deemed to be a true emergency as determined by the claims administrator, PRISM staff will consult with the member and will approve payment if the member agrees and will work with the claims administrator to pay remaining balance of the claim.

Claims Not Covered Under the Plan

PRISM staff has authority to approve up to $1,000 per claim. Any claim greater than $1,000 would be referred back to the member entity for consideration and final approval. The member would submit the claim request on behalf of the patient to PRISM staff along with all of the proper documentation needed to make a determination on the claim (includes appeal paperwork sent to the claims administrator and the administrator's denial letter and any background information explaining why the claim was denied). PRISM staff will consult with the administrator on the specific claim and work with the member to determine if the claim should be paid.

An exception form signed by the member entity is required. This form states that the member understands that making this exception would set payment precedent and may potentially require the member to amend their plan documents. Each member must designate who has the authority to submit the appeal to PRISM staff. For any claim approved by the member entity, PRISM staff will maintain records to ensure that the Committee is made aware of repeated claims for similar conditions prior to making a determination on subsequent claims.

Open Enrollment Timeline

In order to ensure a smooth transition into PRISMHealth and minimize employee disruption, PRISM staff and Alliant strongly encourage members to complete the open enrollment process by November 7th of each year. Adhering to this deadline will help ensure that ID Cards are delivered to employees for January 1st.

Below is the standard timeline for reference.

Date	Activity
August 1	All members must confirm renewal
August 15	Last day for members to confirm plan changes
August 1 – September 30	BenAdmin vendors & Carriers prepare systems with new plans & rates
October 1 - October 31	**OPEN ENROLLMENT**
November 1 - November 7	Final Employer Verifications
November 8 - November 30	BenAdmin vendors create Open Enrollment files & test with Carriers
December 1	All files are sent to Carriers (medical and pharmacy)
December 1 – December 8	Discrepancy reports are analyzed and enrollment is finalized
December 9	ID Cards are triggered and produced
December 20 – December 31	ID Cards are mailed to employees