



# Employee Benefits Program Administrative Guidelines

## Purpose

The purpose of the Employee Benefits (EB) Administrative Guidelines is to provide clear, consistent, and effective guidance to program members participating in the PRISM Dental, Vision, Life/Disability and EAP programs. This guidance seeks 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.

## Dental & Misc. Program Eligibility & 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. COBRA Participants eligible to elect coverage through COBRA.
4. A retiree who meets the eligibility requirements set by the member entity for retiree benefits, including the retiree's spouse/domestic partner and qualified dependents.
5. Retired employees who are currently eligible and participating in the plan will be eligible to continue coverage under the Program, if the coverage permits.
  - a. Retirees who declined 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 the 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.
6. 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 Retiree 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.
7. 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 PRISM Employee Benefits Committee.



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### **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 of the respective member plan, the first of the month following their birth month.

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 of California
- f. Legally Separated Spouse/Domestic Partner
- g. Divorced Spouse (including employees that are required to cover their former spouse based on a court order. The liability is not on the member entity or the Program, the employee must find a plan outside of the group plan to cover the ex-spouse.)

### **Domestic Partners**

PRISM allows coverage for Domestic Partners. 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



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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.



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### **Retroactivity and COBRA**

COBRA Federal guidelines will always be followed without exception. If any member does not have the COBRA guidelines, they may reach out to their Alliant service team to obtain a soft copy of the manual. The Program makes available COBRA administrative services for all Employee Benefits Program members. If a member decides to self-administer COBRA, 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 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 circumstances prevail. 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.



### **Dental & Miscellaneous Program Claims Not Covered Under the Plan**

PRISM staff has the authority to approve up to \$1,000 per claim. Any claim greater than \$1,000, PRISM staff would refer back to the member entity (Employer) for approval. The member would submit the claim request on behalf of the patient to staff along with all of the proper documentation necessary to make a determination on the claim (including appeal paperwork sent to the claims administrator, 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. The form must be signed by someone within the organization that has the authority to submit the appeal to PRISM staff. Authorization will be verified by Alliant prior to submission to PRISM. For any claim approved by the Committee, PRISM staff would maintain records to ensure that the Committee would be made aware of repeated claims for similar conditions prior to making a determination on subsequent claims.