



GREAT REDWOOD TRAIL AGENCY

MEETING DATE: December 5, 2024

AGENDA ITEM: 5. Resolution 2024-11 Participation in the Special District Risk Management Authority Health Benefits Ancillary Coverages

FROM: Elaine Hogan

RE: SDRMA Ancillary Health Benefits

BACKGROUND:

At the September 19, 2024 board meeting, Resolution 2024-09 was approved, adding dental, vision and employee assistance program benefits to the GRTA compensation package outlined in section 0204 of our policy manual. GRTA is a member of the Special District Risk Management Authority (SDRMA) and has opted to receive these ancillary health benefits from them. In order to begin coverage, SDRMA requires board approval of the following documents, which are attached here: a Memorandum of Understanding (MOU), a resolution, and a completed Program Participation Agreement. Staff have reviewed the Administrative Guidelines referenced in the MOU as well as the participation agreement and are prepared to implement the program. Upon approval, GRTA staff are expected to have access to dental and vision insurance and the employee assistance program by February 1, 2025.

RECOMMENDATION:

Adopt Resolution 2024-11 Approving the Form of and Authorizing the Executive Director to Execute the Memorandum of Understanding and Program Participation Agreement for Participation in the Special District Risk Management Authority Health Benefits Ancillary Coverages

FISCAL IMPACT:

No direct fiscal impact. The board has already approved the addition of dental, vision and employee assistance program benefits to our compensation package at an estimated cost of \$32.67 - \$42.04 per month for the employee only or \$82.67 - \$92.04 for the employee and dependents, depending on the plan selected by the employee.

ATTACHMENTS:

- A. ATTACHMENT TWO - MEMORANDUM OF UNDERSTANDING - GREAT REDWOOD TRAIL AGENCY
- B. 2024-11 SDRMA RESOLUTION
- C. ATTACHMENT THREE - PROGRAM PARTICIPATION AGREEMENT - GREAT REDWOOD TRAIL AGENCY (1)
- D. ADMINISTRATIVE GUIDELINES-UPDATED 01.24.2024

MEMORANDUM OF UNDERSTANDING

THIS MEMORANDUM OF UNDERSTANDING (HEREAFTER "MEMORANDUM") IS ENTERED INTO BY AND BETWEEN THE SPECIAL DISTRICT RISK MANAGEMENT AUTHORITY (HEREAFTER "SDRMA") AND THE PARTICIPATING PUBLIC ENTITY (HEREAFTER "ENTITY") WHO IS SIGNATORY TO THIS MEMORANDUM.

WHEREAS, on August 1, 2006, SDRMA was appointed administrator for the purpose of enrolling small public entities into the Public Risk Innovation, Solutions and Management (PRISM) Health and/or Employee Benefits Small Group Program (hereinafter "PROGRAM"); and

WHEREAS, the terms and conditions of the PROGRAM as well as benefit coverage, rates, assessments, and premiums are governed by the PRISM Health Committee and/or PRISM Employee Benefits Committee for the PROGRAM (the "COMMITTEE") and not SDRMA; and

WHEREAS, ENTITY desires to enroll and participate in the PROGRAM.

NOW THEREFORE, SDRMA and ENTITY agree as follows:

1. **PURPOSE.** ENTITY is signatory to this MEMORANDUM for the express purpose of enrolling in the PROGRAM.
2. **ENTRY INTO PROGRAM.** ENTITY shall enroll in the PROGRAM by making application through SDRMA which shall be subject to approval by the PROGRAM's Underwriter and governing documents and in accordance with applicable eligibility guidelines.
3. **MAINTENANCE OF EFFORT.** PROGRAM is designed to provide an alternative health benefit solution to all participants of the ENTITY including active employees, retired employees (optional), dependents (optional) and public officials (optional). ENTITY public officials may participate in the PROGRAM only if they are currently being covered and their own ENTITY's enabling act, plans and policies allow it. ENTITY must contribute at least the minimum percentage required by the eligibility requirements
4. **PREMIUMS.** ENTITY understands that premiums and rates for the PROGRAM are set by the COMMITTEE. ENTITY will remit monthly premiums based upon rates established for each category of participants and the census of covered employees, public officials, dependents and retirees.

Rates for the ENTITY and each category of participant will be determined by the COMMITTEE designated for the PROGRAM based upon advice from its consultants and/or a consulting Benefits Actuary and insurance carriers. In addition, SDRMA adds an administrative fee to premiums and rates for costs associated with administering the PROGRAM. Rates may vary depending upon factors including, but not limited to,

demographic characteristics, loss experience of all public entities participating in the PROGRAM and differences in benefits provided (plan design), if any.

SDRMA will administrate a billing to ENTITY each month, with payments due by the date specified by SDRMA. Payments received after the specified date will accrue penalties up to and including termination from the PROGRAM. Premiums are based on a full month, and there are no partial months or prorated premiums. Enrollment for mid-year qualifying events and termination of coverage will be made in accordance with the SDRMA Program Administrative Guidelines.

5. **BENEFITS.** Benefits provided to ENTITY participants shall be as set forth in ENTITY's Plan Summary for the PROGRAM and as agreed upon between the ENTITY and its recognized employee organizations as applicable. Not all plan offerings will be available to ENTITY, and plans requested by ENTITY must be submitted to PROGRAM underwriter for approval.
6. **COVERAGE DOCUMENTS.** Except as otherwise provided herein, coverage documents from each carrier outlining the coverage provided, including terms and conditions of coverage, are controlling with respect to the coverage of the PROGRAM and will be provided by SDRMA to each ENTITY. SDRMA will provide each ENTITY with additional documentation, defined as the SDRMA Program Administrative Guidelines which provide further details on administration of the PROGRAM.
7. **PROGRAM FUNDING.** It is the intent of this MEMORANDUM to provide for a fully funded PROGRAM by any or all of the following: pooling risk; purchasing individual stop loss coverage to protect the pool from large claims; and purchasing aggregate stop loss coverage.
8. **ASSESSMENTS.** Should the PROGRAM not be adequately funded for any reason, pro-rata assessments to the ENTITY may be utilized to ensure the approved funding level for applicable policy periods. Any assessments which are deemed necessary to ensure approved funding levels shall be made upon the determination and approval of the COMMITTEE in accordance with the following:
 - a. Assessments/dividends will be used sparingly. Generally, any over/under funding will be factored into renewal rates.
 - b. If a dividend/assessment is declared, allocation will be based upon each ENTITY's proportional share of total premiums paid for the preceding 3 years. An ENTITY must be a current participant to receive a dividend, except upon termination of the PROGRAM and distribution of assets.

-
- c. ENTITY will be liable for assessments for 12 months following withdrawal from the PROGRAM.
 - d. Fund equity will be evaluated on a total PROGRAM-wide basis as opposed to each year standing on its own.
9. WITHDRAWAL. ENTITY may withdraw subject to the following condition: ENTITY shall notify SDRMA and the PROGRAM in writing of its intent to withdraw at least 90 days prior to their requested withdrawal date. ENTITY may rescind its notice of intent to withdraw. Once ENTITY withdraws from the PROGRAM, there is a 3-year waiting period to come back into the PROGRAM, and the ENTITY will be subject to underwriting approval again.
 10. LIAISON WITH SDRMA. Each ENTITY shall maintain staff to act as liaison with SDRMA and between the ENTITY and SDRMA's designated PROGRAM representative.
 11. GOVERNING LAW. This MEMORANDUM shall be governed in accordance with the laws of the State of California.
 12. VENUE. Venue for any dispute or enforcement shall be in Sacramento, California.
 13. ATTORNEY FEES. The prevailing party in any dispute shall be entitled to an award of reasonable attorney fees.
 14. COMPLETE AGREEMENT. This MEMORANDUM together with the related PROGRAM documents constitutes the full and complete agreement of the ENTITY.
 15. SEVERABILITY. Should any provision of this MEMORANDUM be judicially determined to be void or unenforceable, such determination shall not affect any remaining provision.
 16. AMENDMENT OF MEMORANDUM. This MEMORANDUM may be amended by the SDRMA Board of Directors and such amendments are subject to approval of ENTITY's designated representative, or alternate, who shall have authority to execute this MEMORANDUM. Any ENTITY who fails or refuses to execute an amendment to this MEMORANDUM shall be deemed to have withdrawn from the PROGRAM on the next annual renewal date.
 17. EFFECTIVE DATE. This MEMORANDUM shall become effective on the later of the first date of coverage for the ENTITY or the date of signing of this MEMORANDUM by the Chief Executive Officer or Board President of SDRMA.
 18. EXECUTION IN COUNTERPARTS. This MEMORANDUM may be executed in several counterparts, each of which shall be an original, all of which shall constitute but one and the same instrument.

In Witness Whereof, the undersigned have executed the MEMORANDUM as of the date set forth below.

Dated: _____

By: _____

Special District Risk
Management Authority

Dated: _____

By: _____

Great Redwood Trail Agency

RESOLUTION
of the
Board of Directors
of
GREAT REDWOOD TRAIL AGENCY

Resolution No. 2024-11

IN THE MATTER OF: SDRMA Health Benefits Ancillary Coverage Resolution No. 2024-11
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WHEREAS, GREAT REDWOOD TRAIL AGENCY (“GRTA”) a public agency duly created and governed by the terms of California Government Code Section 93000 et seq. (the “ENTITY”), has determined that it is in the best interest and to the advantage of the ENTITY to participate in the Health Benefits Program offered by Special District Risk Management Authority (the “Authority”); and;

WHEREAS, the Authority was formed in 1986 in accordance with the provisions of California Government Code 6500 et seq., for the purpose of providing risk financing, risk management programs and other coverage protection programs; and

WHEREAS, participation in Authority programs requires the ENTITY to execute and enter into a Memorandum of Understanding which states the purpose and participation requirements for the Health Benefits Program; and

WHEREAS, all acts, conditions and things required by the laws of the State of California to exist, to have happened and to have been performed precedent to and in connection with the consummation of the transactions authorized hereby do exist, have happened and have been performed in regular and due time, form and manner as required by law, and the ENTITY is now duly authorized and empowered, pursuant to each and every requirement of law, to consummate such transactions for the purpose, in the manner and upon the terms herein provided.

NOW THEREFORE BE IT RESOLVED BY THE BOARD OF DIRECTORS OF THE GREAT REDWOOD TRAIL AGENCY as follows:

Section 1. Findings. The ENTITY's Governing Body hereby specifically finds and determines that the actions authorized hereby relate to the public affairs of the ENTITY.

Section 2. Memorandum of Understanding. The Memorandum of Understanding, to be executed and entered into by and between the ENTITY and the Authority, in the form presented at this meeting and on file with the ENTITY's Secretary, is hereby approved. The ENTITY's Governing Body and/or Authorized Officers ("The Authorized Officers") are hereby authorized and directed, for and in the name and on behalf of the ENTITY, to execute and deliver to the Authority the Memorandum of Understanding.

Section 3. Program Participation. The ENTITY's Governing Body approves participating in the Special District Risk Management Authority's Health Benefits Program.

1 **Section 4. Severability.** If any provision of this resolution or the
2 application thereof to any person or circumstance is held invalid, such
3 invalidity shall not affect other provisions or applications of the
4 resolution which can be given effect without the invalid provision or
5 application, and to this end the provisions of this resolution are
6 severable.

7
8 **Section 5. Other Actions.** The Authorized Officers of the ENTITY are
9 each hereby authorized and directed to execute and deliver any and all
10 documents which are necessary in order to consummate the transactions
11 authorized hereby and all such actions heretofore taken by such officers
12 are hereby ratified, confirmed and approved.
13

14 **Section 6. Effective Date.** This resolution shall take effect immediately
15 upon its passage.
16
17

18 Introduced and adopted this _____ day of December, at a Meeting of the Board of Directors of
19 Great Redwood Trail Agency by the following vote:

20 AYES:
21 NOES:
22 ABSENT:

23 _____
GRTA Chair, Mary Sackett

24 ATTEST:

25 _____
GRTA Executive Director, Elaine Hogan
26
27

To: Great Redwood Trail Agency
From: PRISM / AUS Underwriting
Date: October 31, 2024
Re: **Great Redwood Trail Agency: Small Group Program Application Approval**

We are happy to approve the application of Great Redwood Trail Agency for acceptance to participate in the PRISM Small Group program.

As part of this acceptance, you will find two attachments to this letter:

1. Program Underwriting & Eligibility Rules
2. Program Participation Agreement

The Underwriting and Eligibility Rules are designed to serve as a guide for program rules and expectations. These rules outline expectations of member conduct within the program and have been established to protect both the pool and the member from actions that may increase the cost and/or risk in the program.

The Program Participation Agreement details the final terms of acceptance and any special exceptions or terms that have been made as part of this approval. Please read these terms carefully and contact your representative at SDRMA if you have any questions or require clarification(s).

Great Redwood Trail Agency's completion and execution of the Program Participation Agreement will constitute full acceptance of the organization as a member of the PRISM Small Group program and deem it eligible to participate in the insurance coverage plan(s) applied for and approved in this agreement. **Please return the signed Program Participation Agreement to SDRMA.**

We thank you for your interest in the PRISM Small Group program and look forward to your participation in the program.

Sincerely,

Annalyse Clapp

FOR INTERNAL USE ONLY			
Application is:	☒ Accepted	☐ Rejected	Case No. _____
Effective:	_____ 1/1/2025 _____		Underwriter: _____ Annalyse Clapp
Date:	_____ 10/31/2024 _____		By: <u>Annalyse Clapp</u> (Signature)

SMALL GROUP PROGRAM UNDERWRITING & ELIGIBILITY GUIDELINES

(Subject to attached Custom Contingencies and Caveats section)

Health Program Eligibility Guidelines

Active Full-Time Employees	Full-time salaried or hourly employees who are actively at work at least 30 hours per week.
Active Part-Time Employees	Part-time employees who are actively at work at least 20 hours per week.
Dependent Eligibility	Eligible dependents are covered to age 26 and will terminate coverage first of the month following 26th Birthday. Disabled dependents are covered regardless of age but must be approved by the plan administrator (claim fiduciary medical management) prior to annual enrollment.
COBRA Participants	Eligible to elect coverage through COBRA.
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 AUS and with the approval of the PRISMHealth Committee.
Retirees	To qualify for Medicare plans and rates, retiree must be enrolled in Medicare Parts A&B at their own cost.
	Retired employees who are currently eligible and participating on the plan will be eligible to continue coverage under the program, if the coverage permits. Retirees who declined coverage may not enroll in any coverage at a subsequent enrollment date. Exceptions can be made at the recommendation of AUS.
	Medicare Eligible retirees must enroll in Medicare parts A&B

Health Program Underwriting Guidelines (Continued on next page)

Group Size Requirements	
Minimum/Maximum including Full-Time Eligible Employees, Part-Time Eligible Employees, Non-Medicare Retirees, Medicare Retirees, Board Members, Trustees, Council Members, or Other Elected Officials	Minimum: 2 Maximum: 200
Participation Guidelines	
Active Employees, Non-Medicare Retirees, Medicare Retirees, Board Members, Trustees, Council Members, or Other Elected Officials	• Minimum participation of 75% of all eligible population. • Non-Medicare Retirees will be thoroughly reviewed by AUS if they exceed 20% of the total covered population • Exceptions can be made at the recommendation of AUS and with the approval of the PRISMHealth Committee
Employer Contributions	
Contributions should be structured to allocate cost for tiers with dependent coverage. Cash-Back or "Cash-in-lieu-of" employer contributions are not preferred unless a specific exception has been made by underwriting.	
Gap Funding: Gap funding is an account established to run alongside a health plan that supplements out-of-pocket medical expenses incurred through the plan and that would normally be paid by the covered individual. PRISM offers High Deductible Health Plan (HDHP) options that are underwritten to include the	

use of Health Savings Accounts (HSAs) for gap funding purposes. The program offered HDHPs are not eligible to run alongside Health Reimbursement Arrangements (HRAs) or any other type of external gap funding plan or mechanism. All other medical plans offered within the PRISMHealth portfolio (HMO, Silver PPO, Gold PPO, EPO, etc.) are not considered eligible for gap funding of any type.	
Active Employees, Part-Time Eligible Employees, Board Members, Trustees, Council Members, or Other Elected Officials	Employer pays Minimum 75% of the single-only cost, 50% suggested contribution for dependents.
Retirees	No minimum employer contribution.
Waiting Period	
Date of hire is not allowed unless hire date is on the first of the month. All plan changes resulting from Qualifying Events will be effective on the 1st of the month following the event. Births and deaths are exceptions where coverage will be added/dropped on the event date rather than the first of the month following. If dependents are covered when a retiree or employee passes away, dependent coverage will continue to the end of the month.	
Waivers	
Coverage can only be waived with proof of group coverage through spouse, other group coverage, Medicare/Medi-Cal/Medicaid or COBRA. Waivers will be reviewed by AUS if they exceed 25% of the total covered population. Exceptions can be made at the recommendation of underwriting and with the approval of the PRISMHealth Committee or PRISM staff. Non-Program participants are excluded from this waiver definition (i.e. union carve-out, PORAC).	
Lock-out period	
Small group members will comply with the withdrawal and termination rules of the JPA in which they contract for coverage.	
Plan Selections and Combinations Guidelines	
Plan Selections	Subject to underwriting review and approval: • 2-100 enrolled lives: 2 non-Kaiser plans + 1 Kaiser plan • 101-200 enrolled lives: 3 non-Kaiser plans + 1 Kaiser plan
Plan Combinations	• Only 1 non-Kaiser HMO or HDHP plan may be offered to an employee group • Groups requesting more than 1 non-Kaiser HMO or more than 1 HDHP require approval from PRISM/AUS underwriting • Future plan changes are subject to review and approval by PRISM/AUS underwriting
Other Programs	• The PRISMHealth Program should be offered as a full takeover program in most situations. • The PRISMHealth Program will consider a carve-out option alongside CalPERS exclusively (not dual choice). The current plans and enrollment will be reviewed and approved via the Underwriting process and disclosed to the PRISMHealth Committee. • Other program carve-outs will not be allowed.

Dental, Vision, Life, Disability and EAP Program Eligibility Guidelines

The following underwriting guidelines assume the employer will only be offering the PRISM Small Group coverage plans to an employee group.

Active Full-Time Employees	Full-time salaried or hourly employees who are actively at work at least 30 hours per week.
Active Part-Time Employees	Part-time employees who are actively at work at least 20 hours per week.
Dependent Eligibility	Eligible dependents are covered to age 26 and will terminate coverage first of the month following 26th Birthday. Disabled dependents are covered regardless of age but must be approved by the plan administrator (claim fiduciary medical management) prior to annual enrollment.
COBRA Participants	Dental & Vision: Eligible to elect coverage through COBRA Life/AD&D, Disability, EAP: Not eligible to elect coverage through COBRA
Board members, Trustees, Council Members, or Other Elected officials	Dental, Vision, Life/AD&D, EAP: 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. Supplemental Life and Disability: Not eligible
Retirees	Dental and Vision: Eligible Life/AD&D, Disability, and EAP: Not eligible

Dental, Vision, Life, Disability and EAP Program Underwriting Guidelines

Group Size Requirements	
Minimum/Maximum include Full-time Eligible Employees, Part-Time Eligible Employees, Non-Medicare Retirees, and Medicare Retirees, Board Members, Trustees, Council Members, or Other Elected officials	Minimum: 2 Maximum: Up to 50*
Participation Guidelines	
Active Employees, Retirees and Board Members, Trustees, Council Members, or Other Elected officials	Dental and Vision: 75% of all eligible Life/AD&D, Disability, and EAP: 75% of all eligible (Retirees not eligible)
Employer Contributions	
Contributions should be structured to allocate cost for tiers with dependent coverage. Cash-Back or "Cash-in-lieu-of" employer contributions are not permitted unless a specific exception* has been made by underwriting.	
Active Employees, Board members, Trustees, Council Members, or Other Elected officials	Employer pays 75% of the single-only cost, except for Supplemental Life. 50% suggested contribution for dependents.
Retirees	No minimum employer contribution (for eligible lines of coverage).
Lock-out period	

Small group members will comply with the withdrawal and termination rules of the JPA in which they contract for coverage.

Plan Selection Guidelines

Plan Selection

- Dental: Employers can select 1 Dental PPO plan + 1 Dental DHMO
- Vision/EAP: Employers can select one plan to offer their employees and dependents
- Basic Life and AD&D: Employer can select a plan for each class of employee (Designated by level of benefit)

* At the discretion of Underwriting. See Special Acceptance Terms section of Program Participation Agreement for further detail.

PROGRAM PARTICIPATION AGREEMENT

The coverage and premiums offered under this agreement are based on the information provided. The submission of any false information may result in the denial of coverage. The provision of known false or misleading information shall render this agreement null and void, and any insurance coverage offered hereunder shall be withdrawn retroactively to the effective date of the policy.

Great Redwood Trail Agency is approved for the following products:

Health ☐

Dental ☒

Vision ☒

Life ☐

Disability ☐

EAP ☒

Future underwriting approval is required for coverage not requested / approved above.

Special Acceptance Terms

- Rate proposal assumes full takeover of existing benefit plans and carriers.

Standard Acceptance Terms

- The Underwriting & Eligibility Rules are part of the terms of this agreement and apply unless stated otherwise in the Special Acceptance Terms.
- Proposed rates are guaranteed ONLY for the current population of **Great Redwood Trail Agency**, including all currently covered active employees, retirees and public officials (where approved).
- This proposal includes applicable Affordable Care Act Government Fees (Health plans only).
- Rate proposal assumes current enrollment as provided in census file submitted in Interest Packet. PRISM reserves the right to potentially non-renew if the following changes occur and no corrective action is taken by the member organization:
 - If total program enrollment changes by more than 10%.
 - If the distribution of Actives versus non-Medicare Retirees changes by more than 10%.
 - If the tiered enrollment distribution changes by more than 10%.
 - If employer's contribution towards the employee only cost falls below 75%. This proposal assumes current employer contribution is at least 75% of employee-only cost unless a specific exception has been provided by underwriting. Contribution requirement does not apply to Supplemental Life.

GENERAL AGREEMENT AND SIGNATURE

Effective date requested: _____ (Actual date will be assigned by PRISM if application is accepted). Application is hereby made to PRISM or the appropriate affiliated company for Employee Benefits coverage identified above. If this application is accepted, this Program Participation Agreement will become part of the agreement to join the program.

Upon Acceptance of the application, **Great Redwood Trail Agency** will inform all persons who are eligible for coverage that they may apply for PRISM coverage under the Agreement/Policy. By signing below **Great Redwood Trail Agency** acknowledges receipt of and adherence to PRISM's underwriting and eligibility guidelines and the terms of the Program Participation Agreement.

By: _____ Title: _____
(Authorized Signature)

Printed Name: _____

Special District Risk Management Authority (SDRMA) Health Benefits Administrative Guidelines



We are public employees. Just like you.

Special District Risk Management Authority, referenced as SDRMA in this document, is a public agency formed under California Government Code Section 6500 et seq. and provides a full-service risk management program for California's local governments.

SDRMA was established in 1986 to provide risk financing and risk management services through a financially sound pool to California public agencies, delivered in a timely and responsible cost-efficient manner. Our combined membership totals over 660 individual public agencies throughout California.

In 2006, SDRMA became the administrator for the small group program under the PRISM employee benefits pools. SDRMA's Employee Benefits Small Group Program provides health benefits to agencies that have 2 to 200 full time employees for Medical and 2 to 50 full time employees for Ancillary coverages. SDRMA currently has over 140 agencies participating in the employee benefits small group program and offers Medical, Dental, Vision, Basic Life and AD&D, Short-Term Disability, Long-Term Disability and Employee Assistance Program.



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Purpose

The purpose of the SDRMA Administrative Guidelines is to provide clear, consistent, and effective guidance to agencies and service providers participating in the Employee Benefits Small Group Program. This guidance seeks to educate agencies on administrative processes as structured by the Program. The intent is to preserve the integrity of the Program and each of its participating agency's 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, updated procedures, and applicable regulations.

Any reference to "Agency/Agencies" or "Employer/Employers" in this document is meant to include any publicly funded organization that falls under the category of County, City or Special District and that is a participating agency of the Employee Benefits Small Group Program under SDRMA. It may include any other agency that falls outside of the aforementioned categories if underwriting has approved the employer group to join the Small Group program under SDRMA.

The Employee Benefits Small Group program through SDRMA does not extend coverage to Educational Organizations. Organizations that are not Publicly Funded are not eligible to join the Small Group Program through SDRMA.

Contracts

There is a Memorandum of Understanding (MOU), Resolution, and Program Participation Agreement that must be approved and signed to join the Employee Benefits Small Group Program after the agency has been approved by underwriting. These contracts cannot be amended/customized by the agency. SDRMA must receive originals of the MOU and Resolution from the entity. SDRMA must also receive a copy of the Program Participation Agreement.

As outlined in SDRMA's MOU under Amendment of Memorandum, if SDRMA's MOU is amended by the SDRMA Board of Directors such amendments are subject to approval of agency's designated representative or alternate. SDRMA will send an updated MOU to each participating agency requesting approval of the updated MOU along with an updated Resolution.

Please send the signed original MOU and Resolution to:

Special District Risk Management Authority
Attention: Alana Little – Health Benefits Manager
1112 I Street, Suite 300
Sacramento, California 95814

Program Eligibility

Prior to an agency going through the initial underwriting process to join the Small Group Program, SDRMA also requires an entity enrollment form to be completed by the agency. The entity enrollment form states the Probationary Period/Eligibility Date is always on the **First day of the month following Date of Hire**. SDRMA will follow the First day of the month following Date of Hire waiting period for new hires unless your agency's entity enrollment form specifies a different waiting period, or your agency informs SDRMA in writing of an update to the waiting period during the underwriting process. If your agency updates the waiting period for new hires after the initial underwriting process it is the agency's responsibility to inform SDRMA in writing of the updated waiting period.

Participating Agencies are responsible for verifying all enrollees are qualified to enroll in the Employee Benefits Small Group Program. This includes verification of qualified dependents. Agencies are also responsible for managing mid-year changes including terminations to ensure changes meet the IRS guidelines.

Below is an outline of who is considered an eligible employee for the benefits program. Each agency may have additional rules that would narrow who is allowed to enroll, but the agency may not extend coverage beyond what is allowed without SDRMA's consent.

- Example 1: If an agency would like to extend coverage to grandchildren, the proposed coverage would need to be reviewed by PRISM for consent since grandchildren are not considered as a qualified dependent.
- Example 2: If an agency decided it wants to exclude coverage to spouses, the agency has full right to deny coverage, as the agency's action doesn't exceed what is allowed under the Employee Benefits Small Group Program parameters.

Qualified Subscribers

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 agency must meet the eligibility requirements within the agency's guidelines set for employees.
2. A Part-time employee who is working a minimum of 20 or more hours per week.
3. Agencies with 50 or more Full-time employees that offer medical coverage - Variable Hour, Temporary, Seasonal, and others who become eligible based on the Affordable Care Act (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 agency for retiree benefits (pre and post Medicare) would include the retiree spouse/domestic partner and eligible dependents. To

qualify for SDRMA Medicare plans and rates, retiree must be enrolled in Medicare Parts A&B and cannot be actively working.

6. If you are a new agency with SDRMA, retired employees who are currently eligible and participating on the plan will be eligible to continue coverage under the program, if the coverage permits. Retirees who declined coverage may not enroll in any coverage at a subsequent enrollment date. 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.
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 coverage that was offered prior to the agency joining SDRMA and are subject to the same requirements as Active employees. Exceptions can be made with approval from underwriting.

Qualified Dependents (To age 26)

Qualified Dependents are defined as:

1. Natural Child(ren)
2. Adopted Child(ren)
3. Stepchild(ren)
4. Court-Ordered Dependent (Legal Guardian)
5. Child(ren) of a California State Registered Domestic Partner
6. Other Qualified Dependent(s) of a Registered Domestic Partner
7. Spouse
8. Registered Domestic Partner*
9. Disabled Dependents
10. Others not included above that are claimed for tax purposes, must be approved by PRISM.

Overage-Dependent: When a dependent turns 26, they are considered an over-age dependent. Over-age dependents will be automatically termed off the respective participant plan the first of the month following their birth month. Upon termination of coverage over-age dependents will be provided the opportunity to elect COBRA.

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:

1. Grandchild(ren)
2. Parent(s)
3. Grandparent(s)
4. Niece/Nephew/Sibling
5. Foster child(ren) – Non-Qualified as they are covered by the State Government
6. Legally Separated Spouse/Domestic Partner
7. Divorced Spouse - Including employees who are required to cover their former spouse based on a court order. The liability is not on the agency or the program, the participant must find a plan outside of the group plan to cover the ex-spouse
8. Financial dependents that are not court ordered

Domestic Partners*

SDRMA 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 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.

Documentation to Qualify Dependents:

Dependent Type	Verification Documents
Spouse	– Prior year's Federal Tax Form that shows the couple was married (financial information may be blocked out) – Marriage Certificate for newly married couple where tax return is not available
Domestic Partner	– Certificate of Registered Domestic Partnership issued by State of California – Affidavit of Domestic Partnership Agreement (when applicable)
Children, Stepchildren, and/or Adopted Children up to age 26	– Legal Birth Certificate or Hospital Birth Certificate (to include full name of child, parent(s) name & child's DOB) ○ State Birth Certificates may take 4 to 8 weeks to be received, a Hospital Birth announcement/certificate can be used as proof of enrollment for newborns up to six months old. ○ Participant may need additional time to provide legal birth certificates due to extenuating circumstances, which is acceptable by SDRMA's Employee Benefits Small Group Program. – Legal Adoption Documentation
Legal Guardianship up to age 18	– Legal Court Documentation establishing Guardianship
Disabled Dependents over age 26 (documentation not needed for children under age 26)	– Legal Birth Certificate or Hospital Birth Certificate (to include full name of child, parent(s) name & child's DOB) - If newly being added to the plan. Prior year's Federal Tax Form that shows child is claimed as an IRS dependent (income information may be blocked out) - If newly being added to the plan. – Completed Disabled Dependent Certification Form completed and submitted to the Medical Carrier for approval to add/continue coverage

Mid-Year Qualifying Events

What is a mid-year election change?

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 or Medicaid, and change in coverage under another employer plan. The change the employee wants to make must be consistent with the event that occurred that gives rise to the change.

Employers must furnish a notice of special enrollment rights to eligible employees at or before the time they are first offered the opportunity to enroll. The special enrollment notice may be provided by including it in the employer’s written application materials that are distributed to eligible employees before enrollment. Even if the employer does not distribute written application materials, the special enrollment notice must be distributed at or before enrollment. SDRMA provides the special enrollment rights with Open Enrollment materials each year and with additional documentation for agencies that are new to SDRMA. The document is provided in PDF format and is titled *Annual Notices*.

What is a Section 125 Cafeteria plan?

A cafeteria plan is a separate written plan maintained by an employer for employees which meets the specific requirements and regulations of section 125 of the Internal Revenue Code.

These IRS requirements provide participants an opportunity to receive certain benefits on a pretax basis. The written plan must specifically describe all benefits and establish rules for eligibility and elections.

When an individual elects pre-tax insurance coverage (also known as Section 125 cafeteria plan benefits), they are afforded one opportunity each plan year to make their election for the coming plan year. This has been most commonly known as Open Enrollment. Outside of this time period, individuals are prohibited from making any alterations to their election, including adding, dropping or changing coverage. However, there may be an opportunity for an individual to make a change if they experience a special enrollment event (or a qualifying event) that would allow the individual to make the mid-year election change. Different qualifying events afford different opportunities for the election change. Alliant, PRISM’s broker for the pool compliance team, has provided a grid that identifies these differences. SDRMA will provide a copy of the most up to date compliance document with Open Enrollment materials.

In order to provide pre-tax benefits to employees, the IRS has established rules by which the benefits are to be offered, which includes election periods and eligibility.

One area of concern is a change within the course of a plan year that does not coincide with a qualified mid-year election change. (Example, dropping coverage for an individual without a coinciding qualified mid-year election change event.) If employers making these changes without a qualified event, they risk taxation issues if audited. By continuing to allow changes without a qualified event, it could jeopardize the pre-tax benefit requiring the coverage to be offered post tax.

Mid-Year Qualifying Events refers to both the addition and termination of employee and dependent coverages.

Under the Employee Benefits Small Group Program through SDRMA, 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, and coverage may be added/dropped outside of the first of the month following timeframe.

All Mid-Year Qualifying Events will follow HIPAA guidelines, which allow employees up to 31 days to report the event to their employer. If the change was not reported timely, the employee or retiree will be required to wait until the next open enrollment period to make the change. (Exceptions to terminate due to death are made.)

To notify SDRMA of an employee's termination of employment an agency can email or submit an enrollment form to SDRMA with the following information: Employee Name, last day employee actively worked, if the termination was voluntary or involuntary and the employee's current mailing address. If the termination was involuntary due to gross misconduct and there was a finding of gross misconduct by an administrative body, SDRMA must be provided documentation of the gross misconduct finding. If an employee is involuntarily terminated due to gross misconduct, neither they nor any enrolled dependent(s) will not be offered COBRA.

- Mid-year qualifying events do require the employer HR representative to complete the *Affidavit of New Hire Employee or IRS Mid-Year Qualifying Event* document to make the change in addition to an updated enrollment form. The employer HR representative must verify mid-year qualifying event documentation. Please refer to the documentation table from the previous pages for adding a dependent. Below is a short list of what the HR representative would need to view in order to complete the Affidavit. *Please note: qualifying event documentation listed below should be retained by the agency. Do not send copies to SDRMA.* For Marriage, a marriage certificate
- Divorce, legal separation – court documents
- Loss of other group coverage – loss of coverage notice
- Medicare eligibility – Medicare notice
- For death – a death certificate
- Change in residence impacting plan eligibility – verification of new address
- Name change - a copy of updated Social Security card or updated Driver's License
- Judgements or decree by court – Court documents

This list is not exhaustive. Refer to Mid-Year Qualifying Events Section in the [Appendix Mid-Year Qualifying Events](#) for further information.

Submitting Enrollments/Changes for Health Benefits

For new hire enrollments, retiree enrollments, or mid-year changes such as adding a newborn to coverage, marriage, loss of other group coverage, terminations, or address change, please have the participant complete an SDRMA medical benefits participant enrollment form and/or SDRMA ancillary coverage participant enrollment form (depending on the lines of coverage your agency offers through SDRMA). If

the change request requires supporting documentation the employer HR representative must verify the documentation and complete the Affidavit of New Hire Employee or IRS Mid-Year Qualifying Event document. Please submit the enrollment form and the affidavit to SDRMA via the employer-based portal at www.sdrma.org. SDRMA will contact your agency if there are any questions regarding the request.

Adding Individuals Retroactively (other than COBRA):

- An agency may add an individual within 31 days of the effective date of change.
- If the requested add is between 31 to 90 days from the effective date, the addition will require PRISM staff approval before processing. Requests over 90 days will be reviewed by PRISM staff.

Retroactivity for COBRA

Federal COBRA (and State Cal COBRA, applicable to Medical HMO plans only) guidelines will be followed without exception. If any agency does not have the COBRA guidelines, they may contact SDRMA to receive a soft copy of the manual. The Program makes available COBRA administrative services for all SDRMA Small Group Program agencies.

Rescission

Regulations define “Rescission” for purposes of the Affordable Care Act’s (ACA) 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. In an effort to improve efficiency and uniform administration, retroactive changes to plan coverage will be permitted only as set forth in this document. The plan’s ability to terminate coverage retroactively (“rescind” coverage) is limited by the Affordable Care Act (ACA) and in most cases is not permitted.*

To support this effort, please be sure to monitor invoices and audit coverage on a monthly basis and submit all changes prior to the 23rd of each month.

Rescission Definition

“Rescission” is a cancellation or discontinuance of coverage that has a retroactive effect.

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

1. Termination of coverage that is prospective (e.g., happens at a future date).
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, 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.

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

The plan document states that the agency has the right to retroactively terminate coverage in these circumstances, and agencies 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 plan may require the employee or retiree to pay the total amount of claims back to the program 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 agency by SDRMA.

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 SDRMA 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, SDRMA 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 time period. **SDRMA 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.

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.

Rescission Summary and Recommended Action:

A plan’s ability to terminate coverage retroactively is limited by the ACA. To ensure compliance with ACA rules, the plan limits the circumstances when retroactive terminations will be allowed.

To preserve the right to terminate coverage retroactively on the basis of fraud or intentional misrepresentation, the plan must reserve that right in its Summary Plan Description (and other employee communications), and the employer must provide 30 days advance written notice of its intent to rescind coverage. In general, the employer should be extremely cautious that it has sufficient evidence of fraud before rescinding coverage and should reserve that course of action only when there is clear evidence that the employee’s action was intentional and not inadvertent.

COBRA

Federal COBRA is available to Medical, Dental and Vision plans. SDRMA’s third party administrator, Businessolver, administers COBRA coverage. When SDRMA is notified by the employer of a participant and/or dependent termination for Medical, Dental and/or Vision coverage, Businessolver will send a COBRA packet to the termed participant and/or dependent with information on how to enroll in COBRA along with payment information.

For self-funded plans, federal COBRA is all that is offered. Cal COBRA is not available except for fully insured plans such as Medical HMO.

SDRMA provides monthly COBRA reports to agencies via email if they have participants that have been terminated from active medical, dental or vision coverage in the last 31 days and been notified of the COBRA enrollment option, participants that are currently enrolled in COBRA and participants within the last 31 days that have terminated their COBRA enrollment.

Waivers

Eligible employees must show proof of other group coverage in order to waive Medical/ Prescription Drug coverage. The Medi-Cal Government Plan may be considered other group coverage due to the financial burden that accepting the employer coverage may put on the participant. Otherwise, individual plans, including the California Market Place benefits are not considered other group coverage and would not be a qualified benefit plan to waive employer group coverage.

Retirees may waive coverage without proof of other group coverage; however, as a reminder, they are not permitted to return to the plan once they have waived coverage.

Dependents cannot be added mid-year without a qualifying event. Loss of coverage for a dependent is allowed as a qualifying event if the coverage was group coverage as noted above for the employee. Loss of individual coverage is not considered a qualifying event for a mid-year add. Otherwise, dependents can only be added during the annual enrollment period.

Open Enrollment Timeline

SDRMA Open Enrollment is October 1 - October 31 each year. Below is a timeline of Renewal and Open Enrollment

Medical and Ancillary Renewal and Plan Changes timeline	
May	PRISM Health and Employee Benefits Renewal approved by PRISM Committee
July	SDRMA receives finalized rates from broker SDRMA sends updated Health Benefits brochure that includes rates via email to participating agencies
August	- Participating Agencies automatically renew unless agency informs SDRMA with a 90-day withdrawal notice as outlined in SDRMA MOU. If an agency wants to make a plan change the deadline to changes is August 15th and must be submitted to SDRMA in writing - Late plan changes received from agencies after August 15th will delay open enrollment for the agency - No plan changes will be accepted after September 1st Businessolver and Carriers begin to prepare systems with plan updates and rates
September	Open enrollment materials developed and sent to participating agencies via email
October	– Open Enrollment for SDRMA participating agencies will be held from October 1-31. Participant enrollments will rollover to the next calendar year unless an Open Enrollment change is submitted by the employer to SDRMA. All changes must be submitted to SDRMA by the end of the business day on October 31st
November	1 st -7 th SDRMA completes entry of requested Open Enrollment changes in Businessolver platform 8th – 30th Businessolver creates test file and begins testing files with carriers
December	1 st - New plan year files are sent to all carriers 8th-15th – If applicable based on the Open Enrollment change submitted ID cards are triggered and mailed to participants to be received before January 1 1 st -8 th Discrepancy reports are analyzed by Businessolver and carriers. Enrollment is then finalized 9 th -15 th ID cards are triggered and produced 20 th -31 st ID cards are mailed to participants
January	1st – SDRMA Plans are active and ready for participants access care

New Group Implementation Timelines:

New agencies joining SDRMA may enter upon the first of any month. The Medical, Dental and Vision program renews on January 1 of each year. Basic Life and AD&D, Short-Term Disability, Long-Term Disability and Employee Assistance Program renews on July 1 of each year.

- If an agency joins SDRMA after January 1 for Medical, Dental and Vision, renewal of coverage and rates will occur on the following January 1 in order to become aligned with the SDRMA program cycle.
- If an agency joins SDRMA after July 1 for Basic Life and AD&D, Short-Term Disability, Long-Term Disability and Employee Assistance Program, renewal of coverage and rates will occur on the following July 1 in order to become aligned with the SDRMA program cycle.

For SDRMA to setup a new agency under the SDRMA program, SDRMA must receive an executed MOU, Resolution, and Program Participation Agreement 45 days prior to the agency's requested effective date. Timeframes outside of this may be unfavorable to the outcome.

Below is the preferred timeline for implementations effective January 1st:

SDRMA Small Group Program	
<i>Date</i>	<i>Activity</i>
August 1 – August 15	Agency sends to SDRMA underwriting documents and SDRMA submits request to underwriting for approval. *Underwriting process usually takes 2 weeks
	Agency is approved by underwriting. SDRMA sends approval email to agency along with enrollment form/affidavit, MOU, Resolution, and Program Participation Agreement that needs to be completed/executed by agency. The agency confirms they are joining the SDRMA Program
	Agency sends MOU and Resolution via email and hard copy originals with a wet signature
	SDRMA informs TPA, Businessolver, to setup new group in system
	SDRMA sends additional documentation to agency pertaining to the plans and coverages they are enrolling in • Businessolver and Carriers prepare systems for open enrollment (45-day timeframe needed prior to Open Enrollment)

<i>October 1 - October 31</i>	OPEN ENROLLMENT (OE) Enrollment forms or for agencies with over 20 lives can submit excel workbook of new enrollments
<i>November 1 - November 7</i>	SDRMA enters new enrollments in Businessolver system. If agency is over 20 lives SDRMA will request Businessolver to upload enrollments to Businessolver system assuming agency completed an excel workbook for enrollments SDRMA sends enrollment report to agency for final agency verification of enrollment within TPA system
<i>November 8 - November 30</i>	Businessolver creates Open Enrollment files and preforms file testing with the Carriers
<i>December 1</i>	All files are sent to Carriers (medical, pharmacy, dental, and vision)
<i>December 1 - December 8</i>	Discrepancy reports are analyzed by Businessolver and carriers. Enrollment is then finalized
<i>December 9 – December 15</i>	ID Cards are triggered and produced <i>Blue Shield will not send ID cards in the mail if participants are enrolled on Blue Shield website</i> <i>Kaiser will not send ID cards in the mail if participants have been enrolled with Kaiser in the last 18 months</i> <i>Delta Dental and VSP do not provide hard copy ID cards. ID cards can be obtained through each carrier's website. A participant can register on the website with their SSN the day coverage becomes effective.</i>
<i>December 20 - December 31</i>	ID cards are mailed to participants
<i>January 1</i>	Plans are effective – participants can access care

Reporting

Medical:

As with almost all Joint Powers Authority (JPA) Programs, individual or detailed employer claims data is not available.

PRISM provides SDRMA with a detailed medical utilization report annually. The report is designed to supply SDRMA with useful and actionable data to make informed decisions regarding plan design, cost containment, and wellness efforts. SDRMA reviews the medical utilization report annually and will notify agencies if there have been any plan design changes when rate information is sent in July.

Affordable Care Act (ACA) Employer Reporting

All SDRMA's medical benefits plans follow Affordable Care Act (ACA) guidelines. Throughout the year SDRMA will provide from their broker, Alliant Insurance Services, Compliance Alerts pertaining to the ACA. In addition, SDRMA provides to each agency in late January of each year 1095B forms for each participant that was enrolled in a Self-Funded medical plan during the calendar year that is being reported. For Fully Insured plans that include Blue Shield HMO and Kaiser HMO plans, participants enrolled in these plans will receive a 1095B form direct from the carrier, and SDRMA will not send the agency a 1095B form for that participant.

For agencies that have less than 50 Full-Time employees, SDRMA's TPA Businessolver for Self-Funded plans will transmit 1095B and 1094B data to the IRS on behalf of your agency. SDRMA will inform your agency via email if your data was accepted by the IRS or if the IRS rejected any data that was transmitted. SDRMA will reach out to your agency either stating your data was accepted by the IRS or if there was a discrepancy with your agency's data SDRMA will inform your agency of additional information needed.

For agencies that have less than 50 Full-Time employees but offer Fully Insured plan(s) the carrier (Blue Shield or Kaiser) will transmit 1095B data to the IRS on behalf of your agency for each participant enrolled in the Fully Insured plan(s).

For agencies that have more than 50 Full-Time employees SDRMA will not transmit any data to the IRS for the 1095B or 1094B data because as an agency that has 50 or more Full-Time employees you must complete and submit to the IRS 1095C and 1094C data. If your agency would like a vendor for transmitting 1095C and 1094C data to the IRS SDRMA's TPA Businessolver can be contracted with directly. Please contact SDRMA for Businessolver contact information.

Things to know about how the program is set up

Medical:

- If your agency chooses a High Deductible Health Plan, HSA vendors are not automatically chosen and set up for the agency. The agency may use a bank of their choice or may use the Carrier preferred HSA bank. Related service fees will be billed and paid separately by the agency. These fees are not included in the medical rates provided in the SDRMA Health Benefits brochure.
- Federal COBRA is offered through the SDRMA medical plans; however, Cal COBRA is not offered through SDRMA medical plans or by the Carriers (exception for fully insured HMO plans). Participants will need to secure coverage elsewhere after Federal COBRA is exhausted.
- Actively working Medicare eligible employees will remain enrolled in the active plan until they retire. The family unit must remain together under the active plan while the Medicare active employee remains working. This would include any dependent that obtains Medicare as well.
- For actively working Medicare Aged employees: The employee should advise Medicare that they are on an active plan and show proof of coverage to avoid any Medicare late enrollment fees into the Part B benefit. Medicare will add the eligible employee on the Part A benefit of Medicare. Medicare will be a secondary payer to the active plan. Employee does not need to pay for Part B while on the active plan and can waive that benefit until they move to the retiree plan.

Out-of-Network Emergency Claims

- 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 agency'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.

Pharmacy

- The Pharmacy ID Card is a separate card from the Medical ID card for all plans except High Deductible, Anthem HMO, and all Kaiser Plans. PPO, EPO Blue Shield HMO medical cards will display as No Pharmacy because pharmacy coverage is carved out to Express Scripts.
- For newly enrolled participants to set-up existing prescriptions with Express Scripts please visit the Express Scripts website or contact customer service once ID cards are received.
- Express Scripts uses Accredo Health Group for their specialty drugs. Specialty drugs are dispensed in 30-day supply or less only. All specialty drugs must go through Accredo to be covered.
- Participants using Mail Order will need to request a new prescription for mail order prescriptions. (If a participant is not using mail order, they are *encouraged to request a 90-day mail order supply because of the fourth retail refill allowance*).
- Mail order- if the medication is a new prescription and is a high-cost medication, a 90-day supply may not be given initially and will charge participants only 30-day supply.
- There will be separate Pharmacy out of pocket maximum from the medical plan. The combined total of the separate out of pocket maximums will follow ACA rules. Please refer to the SDRMA Health Benefits brochure for Pharmacy out of pocket maximums.
- Pharmacy Benefits for Medicare Retirees through an Employer Group Waiver Program (EGWP) [also known as: PDP or Medicare Part D] will follow the formulary based on CMS guidelines. SDRMA only has one EGWP plan design. There can be no variation from this plan design. Please request a copy of the SDRMA EGWP plan design if this benefit is being offered.
- Participants cannot decline the pharmacy benefit. Enrollment in the medical plan will trigger an automatic enrollment into the Pharmacy benefit.
- We are unable to accommodate Pharmacy coordination of benefits.
- There are various programs PRISM has purchased that are part of the benefit and savings programs. Some of these programs are: Preferred Generic Program, Smart 90 Incentive and Pharmacy Management programs.
- Pharmacy management programs are put into place to help manage cost for the program ultimately resulting in annual savings on premiums. The following section covers more information about each of these programs.

Clinical Management Package:

The purpose of this program is to allow the Pharmacy Benefit Manager (PBM) to monitor and maintain costs based on the Class of Medications rather than by name brands. Classes of medications are identified by the condition the drug is designed to treat. Consequently, monitoring based on the class

of the Medication provides the ability to address the changes in pricing and newly developed therapies immediately. This enables the PBM to manage cost continually without being limited by a brand name to manage the program. It also allows the experts in pharmaceuticals, i.e., the clinicians, to identify that the right drugs are being provided to the right patient, in the right amount for the condition that is being addressed. Programs benefit the patient by protecting them in physical and financial health. The management includes Prior Authorization, Step Therapy, and Quantity Management. SDRMA can provide an FAQ on each of these programs if interested.

Preferred Generic Program:

If a brand medication has come off patent and a generic equivalent has been created the brand is considered a **“Multi-Source Drug”**. Under the Preferred Generic program, the generic equivalent will automatically be dispensed at the pharmacy when a multi-source brand drug is scripted. If the multi-source brand is dispensed instead of the generic, the member may have to pay the difference between the brand and the generic plus the generic co-pay. The name **“Generic”** would seemingly presume to be a lesser quality drug, but generic medications are equivalent to brand name medications. Each has the same active ingredient and the same effectiveness. The differences between a brand drug and a generic drug are the price, the name, and the inactive ingredients. Most often generics are more reasonably priced which helps mitigate costs.

Smart 90 Incentive:

The Smart 90 Program permits patients to pick up a 90-day supply of their maintenance medication at a local Walgreens or CVS. This does not take away the ability to receive a 90-day supply from the Express Scripts Mail order program. This program is not available for some drugs due to quantity limits. This program is only for maintenance drugs. The Smart 90 Program is designed to increase the access points for patients to receive their maintenance drugs in a 90-day supply. Patients taking a maintenance drug may fill a 30-day supply for the first 3 fills. After the 3rd fill, the patient will need to purchase their script at CVS, Walgreens or through Mail order. Otherwise, patients will pay the mail order co-pay but only receive the 30-day supply. This program helps bring down the annual cost paid by the member because they are filling their prescriptions less times during the year and at a lower overall cost. SDRMA can provide an FAQ on each of these programs if interested. The following programs are automatically added to every group joining the SDRMA Pharmacy benefit program through Express Scripts: Fraud, Waste and Abuse; Hepatitis C Cure Value; Cholesterol Care Value, and Oncology Care Value.

Retiree Administration

Early Retirees

If your agency offers medical coverage to Early Retirees (under age 65) through SDRMA’s medical benefits, dental and /or vision programs and the Early Retiree opts to enroll in coverage, the Early Retiree will be offered the same plan(s) and coverage as your agency’s active employees.

Early Retirees also have the same rates as active employees unless they move outside of California. If an Early Retiree enrolled in medical moves outside of California, only the plan(s) that your agency offers that are listed under Area V in the SDRMA Health Benefits Brochure will be offered to the Early Retiree.

Early Retirees may waive coverage without proof of other group coverage at Open Enrollment; however, as a reminder, Early Retirees are not permitted to return to the plan once they have waived coverage.

If your agency has an Early Retiree enrolled in medical that will be turning 65, SDRMA will send a Medicare Report to your primary contact for medical benefits and inform the contact to reply if the Early Retiree should be terminated from coverage once they turn 65 or if the Early Retiree will continue as a Medicare Retiree.

Medicare Retirees

If your agency offers medical coverage to Medicare Retirees and their spouse and/or dependents, the retiree, and their spouse and/or dependents must enroll in Medicare Part A and Part B coverage at their own expense when they turn 65 to be able to continue their coverage under SDRMA. Medicare Retiree participants must have Medicare Parts A and B to be enrolled in the Medicare Medical plans. When a retiree, spouse and/or dependent turns 65 and enrolls in Medicare Part A and Part B, they will be enrolled in SDRMA's coordination of benefits plan as a Medicare participant. Medicare coverage will become primary coverage and SDRMA coverage will become secondary coverage. If EGWP (Part D Pharmacy coverage) is offered, they will be automatically enrolled in Part D Pharmacy coverage when they enroll in the Medicare Medical plan. Kaiser Senior Advantage participants will be auto enrolled in the Part D plan. A Retiree and/or their spouse may be directly charged additional premiums by Medicare for Part D coverage if their income is above a certain level. The additional premium is referred to as the Medicare Income-Related Monthly Adjustment Amount (IRMAA). The retiree and/or spouse should contact Medicare for additional information about IRMAA.

If a Retiree does not have Medicare A or B, please contact SDRMA about rates and plans for non-Medicare retirees. Retirees who are eligible for Medicare parts A and B but do not enroll in their Medicare A and B benefit must remain in the higher non-Medicare rate provided for Early Retirees until they have obtained their Part A and B benefit. Retirees eligible for Medicare should not remain indefinitely in the non-Medicare rate, so employers and administrators should monitor these participants and ensure they obtain Medicare within 90 days of becoming Medicare eligible. NOTE: Participants who are eligible for Medicare but are still actively working must remain in the active rate along with all their dependents until the participant retires.

Retired participants who obtain Medicare age but are NOT eligible for Medicare can remain indefinitely in the Non-Medicare Retiree rate.

Retirees who decline coverage may not enroll in any coverage or in any future subsequent enrollment date.

If your agency has a medical enrolled Early Retiree and/or spouse/dependent that will be turning 65, SDRMA will send a Medicare Report to your primary contact for medical benefits and inform the contact to reply if the Early Retiree should be terminated from coverage once they turn 65 or if the Early Retiree will continue as a Medicare Retiree.

SDRMA does offer Medicare split family contracts and rates. This would be provided when the employee has retired and there is one participant on a family contract who is eligible for Medicare and the other family participant is not. The family unit, though the enrollment may be split, must remain on like plans. Example: A retiree cannot be enrolled in a PPO plan while their dependent is enrolled in the HMO plan, nor should they be enrolled in two separate carrier benefits.

SDRMA does not offer a Medicare HMO, Medicare Advantage, HMO Part D or Medical only plans. However, SDRMA does offer a Kaiser Senior Advantage Plan. If you would like to know if your agency is within the service area for Kaiser, please ask SDRMA.

For Kaiser Senior Advantage plans: Participants who are retired and who are Medicare eligible, must assign their Medicare Benefits to Kaiser. If a participant does not assign their Medicare to Kaiser, Kaiser will apply Kaiser Penalty Rates which will be much higher than the Medicare Kaiser rates provided to the employer. It is important that Medicare participants assign their Medicare to Kaiser to avoid these added fees.

Medicare plans under SDRMA follow the Medicare guidelines provided by CMS & Medicare. Specifically, you can find the “Medicare & You” annual guide on the www.medicare.gov page under the Tab called “Forms, Help & Resources”. There is also a guide CMS created called “Your Guide to Who pays first” which can be found in the link provided or under the Medicare.gov page / Free Medicare Publications. <https://www.medicare.gov/Pubs/pdf/02179-Medicare-Coordination-Benefits-Payer.pdf>. These resources are created and managed by these entities and are not materials we can alter.

If your agency offers dental and/or vision coverage to Medicare Retirees and their spouse and/or dependents SDRMA must receive an updated ancillary enrollment form notating to move the Medicare Retiree and their spouse and/or dependents to the Medicare Retiree status. Dental and/or vision coverage offered to Early Retirees and Medicare Retirees is the same coverage and premium as offered to active employees.

Retiree Payments

Early Retirees and Medicare Retirees medical premiums will be included on the medical invoice for active employees sent by SDRMA to your agency. Your agency is responsible (if applicable) for collecting any portion of premiums that the retiree must pay according to your agency guidelines. Medical invoice payments made to SDRMA must be paid in full based on the medical invoice sent to your agency and must include payment for retiree premiums. SDRMA does not accept personal checks from retirees for their portion of premium. If your agency submits payment via check, the check must be an agency issued check.

A retiree can request to terminate coverage at any time of the year without an IRS mid-year qualifying event because they are not on current payroll and do not fall under Section 125 Cafeteria Guidelines. Please note 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 parameters provided to agencies to notify SDRMA of the request to terminate coverage.

For further information on billing and premiums please refer to the Billing and Premiums section.

MEDICARE PARTICIPANT ENROLLMENT PROCESS

If your agency's carrier is Blue Shield or Anthem Blue Cross the following is the process for enrolling the participant in the SDRMA Medicare coordination of benefits plan:

When a new retiree or a retiree and/or their spouse/dependent becomes eligible for Medicare an updated medical enrollment form must be completed to confirm their medical enrollment portion. In addition to the current medical enrollment form the Express Scripts Medicare (PDP) for PRISM Medicare Prescription Plan Benefit Election Form must be completed as well to enroll the Medicare participant in Part D Prescription coverage. The Express Scripts Medicare (PDP) for PRISM Medicare Prescription Plan Benefit Election Form also includes current Medicare Part D prescription coverage details that must be given to the participant enrolling in Medicare. Per Medicare & Medicaid Services (CMS) guidelines if a retiree and/or their spouse is newly enrolling in Medicare Part D coverage through Express Scripts they must be provided the following information/documentation **21 days prior to their enrollment effective date.**

- **Letter from your agency stating the following:**
 - Effective date of enrollment
 - How to opt out of plan/who to contact
 - How opting out affects overall benefits both through SDRMA (i.e., once a retiree waives coverage they cannot re-enroll at a later date, if a spouse waives coverage they have to wait until a mid-year qualifying event or Open Enrollment to re-enroll in coverage, etc.) as well as possible Medicare Part D late enrollment penalty.
 - Your employer contact information for the retiree and/or spouse to obtain more information on the plan
- **Express Scripts Medicare (PDP) for PRISM Benefit Overview (found on pages 3-6 of the EGWP Active Election Form Fillable PDF file)**
- **Express Scripts Medicare (PDP) for PRISM Disclosure letter**

If your agency currently has a packet that is sent to newly eligible Medicare retiree's and/or their spouse, please ensure the above information and letters are included in the packet.

If your agency does not have a letter and/or packet in place reach out to SDRMA and we will provide you sample letters and required documentation.

With the completion of the new Express Scripts Medicare (PDP) for PRISM Medicare Prescription Plan Benefit Election Form this will help expedite enrollment into the Medicare Part D Prescription coverage. SDRMA will need to receive both the medical and prescription enrollment form within 31 days of the new retiree or a retiree and/or their spouse/dependent becoming eligible for Medicare. We can process the enrollment before the ID card is received from Medicare. To process the enrollment prior to a Medicare ID card being received we must be provided a copy of the letter from Social Security stating when Medicare

Part A and Part B coverage is effective as well as the Medicare ID Number. Yet, after the Medicare ID card is received, SDRMA will need a copy of the ID card.

The coverage effective date for the Medicare Part D Prescription coverage is contingent on Medicare approving the effective date for the participant. Initially SDRMA will request the effective date of coverage to be the first of the following month after the retirement date or the date that Medicare Part A and Part B is effective. If the effective date needs to be changed to another future date, then the participant will be enrolled in the commercial prescription plan while the Medicare Part D coverage is approved. The date in which the enrollment for Part D prescription coverage is made effective is the effective date that your agency will be billed the Medicare supplemental rate for the retiree and/or spouse/dependent.

The rate will not change to the Medicare Supplemental rate until coverage is effective under the Medicare Part D coverage.

The retiree and/or their spouse/dependent that is a not a Medicare participant will continue coverage under the active Express Scripts prescription coverage. If the retiree is the participant that is moved to the Medicare Part D prescription coverage the spouse and/or dependents active Express Scripts prescription coverage will still be listed under the retiree's name as the primary subscriber.

If your agency's carrier is Kaiser, the following is the process for enrolling the participant in the SDRMA coordination of benefits plan:

As an agency that offers coverage to Medicare Retirees and spouses under Kaiser Permanente Senior Advantage (KPSA) plan, there are specific guidelines that need to be followed to ensure timely coverage. According to SDRMA guidelines the retiree and/or spouse must enroll in Part A and Part B coverage when they turn 65 to continue retiree benefits. SDRMA's goal is to inform you of the most up to date process for enrolling a retiree and/or their spouse in the KPSA plan (**Note: if your agency offers other carrier plans outside of Kaiser through SDRMA please refer to the process for enrollment into that carrier plan as stated above**).

The KPSA enrollment process is as follows:

1. At least 60 days prior to the retiree and/or their spouse/dependent turning 65, the employer must reach out to the participant turning 65 and inform the participant of the option of enrolling in the Kaiser Permanente Senior Advantage (KPSA) plan. The KPSA plan also includes prescription coverage. The employer must send to the participant turning 65 the SDRMA medical benefits participant enrollment form, current Kaiser KPSA election form, current KPSA Summary, and KPSA Medicare Guide.
2. If the retiree and/or spouse/dependent who is eligible wants to enroll in the KPSA plan they will need to mail to your agency **at least 3 weeks prior to their Medicare Part A and Part B effective date** the following documents completed in their entirety (if forms are not completed in their entirety this will delay the enrollment process):

- a. SDRMA Medical Benefits Participant Enrollment Form-Kaiser Fillable PDF. This enrollment form should include the retiree and/or spouse/dependents that will be enrolled in the KPSA plan and the regular Kaiser plan offered by your agency
 - b. Kaiser KPSA Election Form-This enrollment form should only include the information for the retiree and/or spouse/dependent that is enrolling in the KPSA plan. ***Please ensure to inform the KPSA enrollee they should not send the KPSA form to Kaiser directly, but should send it directly to your agency***
 - c. Copy of Medicare Part A and Part B ID card listing the effective date of coverage for Part A and Part B
3. As an employer when you receive the *Kaiser KPSA Election Form*, please place a receipt date stamp on the form of when as an employer you received the enrollment form. This date stamp will be used by Kaiser Permanente to ensure the correct effective date is issued
 4. Once you as an employer receive the following documents:
 - *SDRMA Medical Benefits Participant Enrollment Form-Kaiser Fillable PDF*
 - *Kaiser KPSA Election Form*
 - *Copy of Medicare Part A and Part B ID card*

Please send copies of these documents via SDRMA employer-based portal at www.sdrma.org. Once SDRMA receives these documents we will enter the enrollment into our third-party administrator's system. Please note that Medicare dictates the effective date of the KPSA plan. Therefore, it is important to sign and return the documents prior to the Medicare eligible effective date to ensure the effective date is close to the date the participant turns 65.

5. **7 business** days after the documents that are listed under number 4 are sent to SDRMA please send a copy of the *Kaiser KPSA Election Form* to Kaiser at the following address:
Mail: Kaiser Permanente – Medicare Unit
P.O. Box 232400
San Diego, CA 92193-2400

IMPORTANT INFORMATION TO INCLUDE WITH KPSA ENROLLMENT FORM: In the cover letter sent to Kaiser please include the Group and Enrollment Unit listed in the below chart that coordinates with the plan your agency offers (\$15 HMO or \$20 HMO) and the Region the retiree lives in. The Region the retiree lives in will dictate if they are enrolled in Northern CA Kaiser or Southern CA Kaiser coverage. Please use the correct KPSA enrollment form attached (either Northern or Southern) based on the Region your retiree lives in. If a retiree does not live in a service zip code that Kaiser covers, they will not be able to be enrolled in the KPSA plan. If you need to check on covered service zip codes before sending a KPSA packet to a retiree, please feel free to reach out to SDRMA to verify the service zip code.

<u>SDRMA HMO Regions</u>		Geographic Locations	Group # & Enrollment Unit	Region & Plan Offering
1	Northern California: Bay Area	Alameda, Amador, Contra Costa, Marin, Napa, Nevada, San Francisco, San Joaquin, San Mateo, Santa Clara, Santa Cruz, Solano, Sonoma, Sutter, Yolo, Yuba	Group #605434 - 2	RGN 1 - \$15 HMO RETIREE
			Group #605434 - 12	RGN 1 - \$20 HMO RETIREE
2	Northern California: Other Counties	Alpine, Butte, Calaveras, Colusa, Del Norte, Glenn, Humboldt, Lake, Lassen, Mariposa, Mendocino, Merced, Modoc, Mono, Monterey, Plumas, San Benito, Shasta, Sierra, Siskiyou, Stanislaus, Tehama, Trinity, Tuolumne	Group #605434 - 102	RGN 2 - \$15 HMO RETIREE
			Group #605434 - 112	RGN 2 - \$20 HMO RETIREE
3	Southern California: Los Angeles Area	Los Angeles, San Bernardino, Ventura	Group #233392 - 2	RGN 3 - \$15 HMO RETIREE
			Group #233392 - 12	RGN 3 - \$20 HMO RETIREE
4	Southern California: Other Counties	Fresno, Imperial, Inyo, Kern, Kings, Madera, Riverside, Orange, San Diego, San Luis Obispo, Santa Barbara, Tulare	Group #233392 - 102	RGN 4 - \$15 HMO RETIREE
			Group #233392 - 112	RGN 4 - \$20 HMO RETIREE
6	Northern California: Sacramento Area	El Dorado, Placer, Sacramento	Group #605434 - 202	RGN 6 - \$15 HMO RETIREE
			Group #605434 - 212	RGN 6 - \$20 HMO RETIREE

- After the KPSA enrollment for the participant is processed by Kaiser (processing takes 10 days from the time that Kaiser receives the KPSA enrollment form) Kaiser will send to the KPSA participant a welcome letter along with the additional documents and ID cards. This is confirmation the retiree was enrolled in the KPSA plan, and it will include the effective date. If there was an issue with processing the KPSA enrollment Kaiser will send to the KPSA participant a letter requesting further information. This letter is time sensitive and could impact the KPSA enrollment approval.

Dental

The PRISM Dental program is a Self-Funded program with fixed rates.

- The fixed rates are comparable to a fully insured premium rate. Rates will not fluctuate due to claim utilization during the plan year.

SDRMA Dental fixed rates renewals are underwritten and renewed on its own merit under the PRISM pool.

All Dental groups that have fixed rates under PRISM are rated together but may receive renewal rate changes different from the pool average based on their own claim experience. Rates renew January 1.

The SDRMA Dental HMO Program is a fully insured program and offers only fully insured premium rates. Rates do not fluctuate due to claim utilization during the plan year.

The SDRMA Dental HMO Program offers three set plan designs with regional rates and renews each year on January 1. The entire Dental HMO Program will renew together as a pool, and SDRMA will receive the same renewal rate change as the rest of the pool under PRISM.

Claims Process

After receiving treatment, there are two ways for a participant to submit a claim. If the participant visits a Delta Dental dentist, the dentist will submit the claim(s) and paperwork for the participant.

If a participant visits a non-Delta Dental dentist, the member must complete items 1 through 15 on the claim form (claim forms can be obtained on the Delta Dental website, www.dentaldeltains.org). Attach a copy of the dentist's statement of treatment, including the dentist's name and phone number (with area code). Delta Dental will use the dentist's statement to process the claim. It's very important that the statement include a description of each service the dentist performs.

Once completed, the participant should make a copy of the form for their records and mail the original to the address on the form.

Claims are processed within 2 weeks unless additional information is required.

Vision

The SDRMA Vision Program under PRISM is a fully insured program and offers only fully insured premium rates. Rates do not fluctuate due to claim utilization during the plan year. The SDRMA Vision Program through VSP offers five set plan designs and renews each year on January 1. The entire fully insured program will renew together as a pool, and SDRMA will receive the same renewal rate change as the rest of the pool under PRISM.

Claims Process for Participating Provider

Once a participant makes an appointment with a VSP provider of their choice, they must notify the provider of their vision coverage in order to receive benefits. The VSP provider will contact VSP to verify eligibility of benefits. The VSP provider will submit the claim form to VSP. The enrollee does not need to submit a claim form when visiting a VSP provider but must identify themselves as having coverage through VSP in order to receive benefits.

Claims Process for Non-Participating Provider

When services and/or materials are obtained from a non-VSP provider, participants should use the following steps to receive the allowed reimbursement:

1. Pay the non-VSP provider the full amount of the bill and request an itemized copy of the bill. The bill should separately detail the charges for the eye exam and materials, including lens type.
2. Include the following information with the bill:
 - The name, address, and phone number of the non-VSP provider
 - The covered participant's ID number
 - The covered participant's name, address, and phone number
 - The name of the group
 - The patient's name, date of birth, address, and phone number
 - The patient's relationship to the covered participant (such as self, spouse, child, student, etc.) Participants can simply write the information on the bill or use the printable form available when members sign on to view benefits information at www.vsp.com.
3. Please send a copy of the itemized bill with the above information to VSP to:

VSP

P.O. Box 997105
Sacramento, CA 95899-7105

Please note that claims for reimbursement must be filed within six (6) months of the date of service. Participants will be reimbursed according to the out-of-network reimbursement schedule.

VOYA Basic Life and AD&D, Supplemental Life, Short-Term Disability and Long-Term Disability (LTD)

The SDRMA VOYA self-administered programs are part of the PRISM pool. The Basic Life and AD&D, Supplemental Life, Short-Term Disability, and Long-Term Disability programs have several options available for coverage and renew each year on July 1. The renewal is together as a pool and SDRMA will receive the same renewal rate change as the rest of the pool under PRISM.

Basic Life and AD&D have value added services for travel assistance, funeral planning and EAP services through ComPsych at no extra cost to participants.

Claims Process

For claims processing please refer to your agency's VOYA administration guide

Basic Life and Supplemental Life conversion when termination of employment occurs

When an employee that was enrolled in Basic Life and/or Supplemental Life terminates employment your agency must provide the termed employee the following VOYA forms: *(please note the forms provided to the termed employee can be blank and only need to be completed if the termed employee wants to convert their Basic Life and/or Supplemental Life)*:

1. If a terminated employee would like to convert their **Basic Life Insurance**, as an employer, you are responsible for completing and providing the termed employee the VOYA Life Conversion Information Request Form. For access to the Life Conversion Information Request Form refer to your agency's VOYA administration guide.
2. If a terminated employee would like to convert their **Supplemental Life Insurance**, as an employer, you are responsible for completing and providing the termed employee the VOYA Term Life Coverage Continuation Request Form. For access to the Term Life Coverage Continuation Request Form refer to your agency's VOYA administration guide.

Employee Assistance Program (EAP)

The carrier for the Employee Assistance Program offered by SDRMA is Concern. Concern provides the following services for Employees: Face to Face and Telephonic Counseling, Legal, Financial Services, etc. Concern provides the following for Employer Services: Brown Bag Seminars, Critical Incident Stress Debriefing, Management Consultations and Management Training.

Employees and Employers can easily access EAP services by referring to the Concern summary provided by SDRMA that lists their employers company code.

Rates renew July 1

Administration

SDRMA is the plan administrator for all programs offered under SDRMA's medical and ancillary benefits. SDRMA does utilize PRISM contracted vendors. These vendors provide core administrative services to SDRMA's Small Group Program.

Administration	Carriers
Medical	Anthem, Blue Shield, Kaiser
Pharmacy	Express Scripts (PPO, EPO, and Blue Shield HMO plans)
Dental	Delta Dental
Vision	VSP
Life and Disability	Voya
EAP	Concern
Administration	Third Party Administrators (TPA)
Medical/ Pharmacy Billing/Eligibility	Businessolver
Dental Billing/Eligibility	Businessolver/Benefit Coordinators Company (BCC)
Vision (VSP) Billing/Eligibility	Businessolver/Benefit Coordinators Company (BCC)
Life and Disability Billing	Businessolver
EAP Billing	PRISM Staff (self-billing) Businessolver

Services provided through Third Party Administrator (TPA)

Medical, Dental, Vision, Basic Life and AD&D, Short-Term Disability, Long-Term Disability and Employee Assistance Program:

- Enrollment Eligibility
 - On-line enrollment that SDRMA processes for each agency
 - Mid-year plan changes that SDRMA processes for each agency
 - Open Enrollment managed by SDRMA
- Billing
 - Consolidated billing/invoicing
 - Reconciliation
 - Remittance of payments to carriers and other partners
- COBRA Administration
- Reporting
 - Census, open enrollment reports, etc.
- ACA Employer reporting

Networks Used for Medical and Pharmacy

The following tables identify the networks being used for both Medical and Pharmacy services.

The services for pharmacy coverage are accessed through a separate Express Scripts Pharmacy ID Card. For the Anthem HMO and both Anthem and Blue Shield HDHP plans, the Medical ID card should be used to access the pharmacy benefit.

For the Kaiser plans, participants will receive a Kaiser ID Card for all access.

Each table below has been created based on the Medical Carrier. Be sure to reference the table pertaining to the medical carrier being accessed.

ANTHEM NETWORK OF PROVIDERS			
Benefit	ASO Network	HMO Network	HDHP
Medical	PPO & EPO Network is the Blue Cross PPO (Prudent Buyer)	Blue Cross HMO (CaliforniaCare)	PPO & EPO Network is the Blue Cross PPO (Prudent Buyer)
Retail Rx	Express Scripts Retail Network	Carelon	Carelon
Mail Order Rx	Express Scripts Pharmacy	Carelon	Carelon
90 Day Supply	Walgreens and CVS	Blue Cross HMO (CaliforniaCare)	See Mail Order Rx
Specialty RX	Accredo Specialty Health (When a medical claim - CVS Caremark)	Carelon	Carelon
Mental Health / Substance Abuse	Prudent Buyer/Anthem's BHN	Providers within the PMG/IPA or Anthem's BHN	Prudent Buyer/Anthem's BHN
Disease Management	Prudent Buyer (DM Program)	Prudent Buyer (DM Program)	Prudent Buyer (DM Program)
Durable Medical Equipment	Blue Cross PPO	Blue Cross HMO	Blue Cross PPO
Chiropractic	Prudent Buyer	Providers within the PMG/IPA or ASH	Prudent Buyer
Acupuncture	Prudent Buyer	Providers within the PMG/IPA or ASH	Prudent Buyer

BLUE SHIELD OF CALIFORNIA NETWORK OF PROVIDERS			
Benefit	ASO Network	HMO Network	HDHP
Medical	Blue Shield PPO Network	Blue Shield HMO Network	Blue Shield PPO Network
Retail Pharmacy	Express Scripts	Express Scripts	CVS Caremark
Mail Order Rx	Express Scripts Pharmacy	Express Scripts Pharmacy	CVS Caremark Mail Service
90 Day Supply	Walgreens and CVS	Walgreens and CVS	See Mail Order Rx
Specialty Pharmacy	Accredo Health Group	Accredo Health Group	CVS Caremark Specialty
Mental Health / Substance Abuse	Blue Shield PPO Network	Magellan	Blue Shield PPO Network
Disease Management	Blue Shield Condition Management Program	Blue Shield Condition Management Program	Blue Shield Condition Management Program
Durable Medical Equipment	PPO – Blue Shield Network providers	HMO – Through Medical group	PPO – Blue Shield Network providers
Chiropractic	Blue Shield PPO Network	ASH	Blue Shield PPO Network
Acupuncture	No true "network" provider must be licensed all paid at in-network level	ASH	No true "network" provider must be licensed all paid at in-network level

KAISER NETWORK PROVIDERS	
Benefit	HMO Network
Medical	Kaiser Permanente Network
Retail Rx	Kaiser Permanente Network
Mail Order Rx	Kaiser Permanente Network
Specialty Rx	Kaiser Permanente Network
Mental Health/Substance abuse	Kaiser Permanente Network
Disease Management	Kaiser Permanente Network
Durable Medical Equipment	Kaiser Permanente Network
Chiropractic	ASH
Acupuncture	ASH

Billing and Premiums

Medical:

SDRMA medical and ancillary (Dental, Vision, Basic Life and AD&D, Short-Term Disability, Long-Term Disability and Employee Assistance Program) premiums are invoiced one month in advance. SDRMA medical and ancillary invoices are posted to MemberPlus as one invoice (if your agency offers both medical and ancillary)) around the 5th of every month. The invoice due date is around the 22nd of every month. An example for reference is April medical and ancillary invoice is posted on March 5 and payment is due to SDRMA by March 22.

Medical invoices **must be paid in full as billed** by the specified due date listed on the invoice. If payment is not received by the due date listed on the invoice interest will accrue at the rate of 1% per month, twelve percent (12%) per annum. Failure to pay premiums can result in your agency being terminated from SDRMA's benefits program.

If changes are submitted to SDRMA after the 23rd of each month they will not reflect until the next month's invoice. An example for reference is a change was received by SDRMA on February 26. The change will reflect on the May invoice. For information on how to submit changes to SDRMA please refer to the Submitting Enrollments/Changes for Health Benefits section.

If your agency would like to receive hardcopy invoices, simply send this request to SDRMA in writing.

Value Added Programs

CARRUM Health-Additional Surgical Benefit

For active employees, early retirees, COBRA participants and their dependents who are enrolled in PPO, EPO or High Deductible health plans, SDRMA offers an additional surgical benefit through Carrum Health. This allows participants access to an enhanced surgery benefit program with top-quality hospitals and surgeons. Carrum Health is a surgical benefit coordinator that offers fixed cost pricing for specific procedures performed exclusively at Stanford Health Care (Valley Care), Providence Saint John's Health Center, and Scripts. The significant cost reduction has a potential of substantial claims savings, on an average of 30% per procedure! Carrum is a 100% voluntary "add-on" benefit that expands the options for participants. Therefore, there will be no changes or limitations to existing benefits. In addition, there are no medical bills, as co-insurance and deductibles will be waived, and applicable travel expenses will be covered for the patient and one adult companion. ***Please note:** This offering is not available to participants enrolled in an HMO plan or Medicare Retirees and the use of this benefit is optional. This benefit is separate from, and in addition to, the benefits already provided under your current Health Care provider, and it is not administered by SDRMA. This benefit must be accessed through Carrum Health and their Care Concierge, who will support you throughout the entire process.

Eligible procedures currently include:

- Knee Replacement
- Hip Replacement
- Coronary Bypass
- Lumbar Spinal Fusion
- Cervical Spinal Fusion
- Bariatric Surgery

*** *Additional procedures will become eligible on a regular basis***

For additional information and flyers for Carrum please contact SDRMA

Wellness - SOLERA

Solera is a program for Diabetes Prevention. Employees or eligible retirees enrolled in Blue Shield or Anthem Blue Cross coverage through SDRMA can simply go to the Solera website: solera4me.com/prism and take a test to find out if they are eligible for the Diabetes Prevention Program.

For additional information and flyers for Solera please contact SDRMA

For additional information and flyers for Wellvolution please contact SDRMA

Wellness – Blue Shield, Anthem Blue Cross and Kaiser

Under each medical carrier enrolled participants have access to free Wellness programs. SDRMA provides Wellness Program information during Open Enrollment and at different times throughout the year.

For additional information and flyers for Wellness through Anthem Blue Cross and Kaiser please contact SDRMA

Appendix Mid-Year Qualifying Events

Section 125 Cafeteria Plans must follow the general principle that participant elections are irrevocable for the period of coverage (generally for the plan year). However, the IRS has recognized certain exceptions to the irrevocability rule — often referred to as mid-year election changes.

Below is a table that shows the events giving rise to possible mid-year election changes.

Quick Reference Table of Permitted Election Change Events		
Events Permitting Election Change	Applicable Benefit Election	Notes/Examples
1. Change in Status <i>Seven categories of events:</i> • Marriage/Divorce • Change in # of dependents (by way of birth, adoption, or death) • Change in employment status if it impacts eligibility • For employees in a stability period, a change in status resulting in a reduction in hours, even if the change in status doesn't	Applies to elections for all qualified benefits (e.g., health coverage, health FSA and DCAP benefits) with the exception of changes in status resulting in a reduction in hours even if the change doesn't impact plan eligibility.	• Employee has a baby; can modify pre-tax election to add family coverage • Employee gets divorced; can modify pre-tax election from employee and spouse coverage to employee-only coverage • Dependent child turns 26 and is no longer eligible for coverage; employee can modify pre-tax election to drop dependent's coverage • Employee changes to part-time position and is no longer eligible for plan; can modify pre-tax election for coverage (to drop coverage) • Note that changes in employment status must affect eligibility for the plan (i.e., dropping from a 40hr./week position to 32 hr./week position would not justify a pre-tax election change if eligibility for the plan isn't

impact plan eligibility (employee can drop coverage to enroll in Exchange or other MEC plan) • Change in dependent status (becomes eligible or ceases to satisfy eligibility req.) • Change in residence that impacts eligibility under the plan • Commencement or termination of adoption		affected) • Financial hardship alone will not justify an election change (i.e., moving from a high paid position to a lower paid position)
2. Cost Changes With Automatic Increase/Decreases in Elective Contributions. For example, a change in premium during the plan year.	Applies to elections for all qualified benefits except health FSAs.	• Allows participants to change their election amount to correspond with cost adjustments due to benefit changes in the plan • Permits mid-year election changes on account of a cost change with automatic increases/decreases in election contributions (e.g., employer changes benefits or contribution mid-year).

3. Significant Cost Change. Allows participants to make a mid-year corresponding and prospective election change (broader than item 2 and may include add/drop due to a significant cost change).	Applies to elections for all qualified benefits except health FSAs.	• Election may be dropped if there is a significant cost increase, and no similar coverage is available. The concept of similar coverage is somewhat complex. Please see the FAQ for further information on similar coverage. • Election may be added if there is a significant cost decrease and participant previously did not enroll due to cost (note that the underlying health plan must allow the mid-year enrollment also). • IRS provides little guidance on what
		is considered “significant.” Generally, the plan will have to use its judgment to determine whether a cost change is significant. See FAQ.
4. Significant Coverage Curtailment. (With or without loss of coverage)	Applies to elections for all qualified benefits except health FSAs.	Employee can make an election change to choose alternative similar coverage or, if unavailable, to drop coverage altogether. Coverage curtailment includes significant increases in cost-sharing. Coverage curtailment resulting in a loss of coverage includes elimination of a benefit package, HMO ceasing in area of residence, substantial decrease in providers, or a reduction in benefits for specific type of medical condition being received by the employee.

5. Addition or Significant Improvement of Benefit Package Option.	Applies to elections for all qualified benefits except health FSAs.	If a plan adds a new benefit package option or other coverage option is significantly improved during a period of coverage, then the employee may change their election to add the new coverage.
6. Change in Coverage Under Other Employer Plan.	Applies to elections for all qualified benefits except health FSAs.	• Open Enrollment Under Other Employer Plan/Different Plan Year. Corresponding changes can be made under employer's plan if employee, spouse, or dependents drop/add during OE of other employer coverage. Avoids the problem with "election lock" where spouses have plans with different plan years. • Other Employer Plan Increases Coverage. Employee may decrease or revoke election for employee, spouse or dependents making election on other employer plan, usually adding other employer coverage. • Other Employer Plan Decreases Coverage. Employee may enroll or increase election (add spouse, dependents) if spouse, dependents currently on other employer coverage experience a decrease in coverage. <i>Note that none of these are HIPAA special enrollment rights so the plan has the option whether or not to allow individuals on to the plan in these circumstances.</i>

7. Loss of Group Health Coverage Sponsored by Governmental or Educational Institution.	Applies to elections for all qualified benefit except health FSAs.	Can make election change to come on employer plan. Applies only to loss of coverage for: • SCHIP State Children's Health Insurance Program • IHS Indian Health Service or other government tribal coverage. • State health benefits risk pool. • Foreign government group health plan.
8. HIPAA Special Enrollment Rights.	Applies to elections for group health plans that are not excepted benefits under HIPAA (usually health FSA, and separately insured dental and vision benefits are considered excepted benefits). A special enrollee is entitled to select any benefit package under the plan, and the plan may not limit the employee's right to change from one benefit package to another upon special enrollment.	HIPAA special enrollment rights include: • Loss of coverage under another group health plan or health insurance. See FAQ after this chart for further information on what constitutes health insurance. Permitted for employees and dependents who are otherwise eligible but had other coverage when previously offered coverage. • Acquisition of new dependent by marriage, birth, or adoption. • Loss of eligibility for Medicaid or CHIP (permitted 60 days after loss of eligibility to notify the plan) • Gain eligibility for premium subsidy under Medicaid or CHIP (permitted 60 days after loss of eligibility to notify the plan) • Allows for <i>retroactive</i> changes when notified within 30 days of event for birth, adoption, or placement for adoption. For marriage, coverage must be effective the first of the month following the request for enrollment. Note: HIPAA special enrollment rights in many cases overlap with the change-in-status events.

9. Exchange Open or Special Enrollment Period	Applies to elections for all qualified benefits except health FSAs.	- An employee enrolled in a non-calendar year plan can drop coverage mid-plan year to enroll in an Exchange plan during Exchange open enrollment. - An employee that has a special enrollment right event can drop calendar or non-calendar year employer coverage to enroll in an Exchange plan. 1
10. COBRA Qualifying Events.	Applies to elections for group health plans subject to COBRA, including health FSAs.	Employee may increase, decrease, or revoke contributions to corresponding COBRA event.
11. Judgments, Decrees, or Orders (such as child support orders, including Qualified Medical Child Support Orders "QMSCOs").	Applies to Decrees, or Orders (such as child support orders, including Qualified Medical Child Support Orders "QMSCOs").	A judgment, decree or order resulting from a divorce, legal separation, annulment or change in legal custody that requires accident and health coverage be provided for an employee's child or foster child permits changes if: To cancel: order requires the child to be on other plan. To add: order requires the child to be on employee's plan.
12. Medicare or Medicaid Entitlement.	Applies to elections for plan's health coverage, including health FSAs	Corresponding election changes for Medicare/Medicaid entitlement, usually dropping employer plan.
13. FMLA Leaves of Absences.	Applies to health coverage elections, including health FSAs.	Employees are entitled to remain on the plan with the same employer contribution during FMLA leave. The employee can also revoke their election during FMLA leave and make an election for coverage upon return from leave. If employee chooses to remain on the plan, there are three ways the regulations permit employees to handle their elections - Prepay – may change election to correspond with event. - Pay-as-you-go – may change election

		to the extent an employee has compensation – balance is after-tax. • Catch-up – may change election to adjust for missed contributions during leave.
14. Changes in Pre-tax HSA Contributions.	Applies to elections to make HSA contributions under a cafeteria plan.	IRS Notice 2004-50 concluded that employees may change their HSA elections prospectively anytime.

FAQ

STATUS CHANGE EVENTS

1. An employee was enrolled in an HDHP but just had a child and wants more comprehensive coverage. What is she allowed to do?

This event is a status change that is also a HIPAA special enrollment right (birth). She can change her election and move from the HDHP plan to another plan and can also add her spouse and new baby. Coverage for the baby would be retroactive to the date of birth. This is the one occasion where retroactive election changes are specifically permitted.

2. An employee is transferred to an office in a different state. Can he make any mid-year election changes?

Yes — under certain circumstances. The change in status rules allow mid-year election changes when a change in residence affects an employee's (or dependents') eligibility for coverage. This is most often the case with HMO coverage where an employee moves out of or into the service area. As with all mid-year election changes, any change must be consistent with the event in question.

COST AND COVERAGE RULES

3. What if the plan increases the premium in the middle of the plan year?

Plans are allowed to automatically increase (or reduce) employee contributions to reflect mid-year cost changes. If the cost change is significant, employees might be permitted to change their elections under the guidelines set forth in question 6 below.

4. What is a “significant cost change” that would allow an employee to change plans or drop coverage?

There is no direct guidance on what makes a cost change significant. The IRS provides some examples of significant cost changes but also warns they are not to be used as safe harbors. Plan administrators must make decisions based on the facts and circumstances. The percentage dollar increase, and actual dollar increase can both be taken into account (a 50% increase to a \$5/month dental premium may not be significant, but a 15% increase could be significant to a plan with pricey premiums. A significant cost change result from employer action (such as reducing employer contributions) or from employee action (switching to part-time where employer pays a smaller portion of premiums) Note, however, where an employee’s pay decreases, if the employer contribution remains the same, the employee cannot make an election change under the cost and coverage rules. See question 7.

5. When looking at whether an employee can change an election for a significant cost change, the rules allow a change to other “similar coverage” or, if that’s not available, a drop in coverage. What is “similar coverage” for these purposes?

The IRS definition is: “Coverage for the same category of benefits for the same individuals (e.g., family to family or single to single).” For example, two plans that provide coverage for major medical are considered to be similar coverage as long as coverage extends to the same people, i.e., employee plus spouse, or family coverage. Note there is no cost component to the definition of similar coverage. If the employer offers “similar coverage”, regardless of the cost, the employee cannot drop coverage altogether. In addition, another employer’s plan can be similar coverage so an employee for whom the cost of coverage increased significantly could enroll in a spouse’s employer plan if that plan provided similar coverage.

6. What if the employee goes from full-time to part-time, the employer contribution toward the premium remained the same, but the employee can no longer afford the premium?

A change in financial circumstance is not itself a permissible mid-year election change event. This is true even in cases of financial hardship.

COVERAGE UNDER ANOTHER EMPLOYER PLAN

7. An employee wants to drop his existing coverage and join a spouse's plan, but the spouse's open enrollment period is a couple months after ours. Can the employee make an election change to switch to the spouse's plan or should they not enroll and go without coverage for two months?

A change in coverage under another employer plan is a permitted mid-year election change event. The employee can make a pre-tax election to pay for employer-sponsored coverage then change the election (drop coverage) when enrolling in the spouse's plan. This avoids "election lock": without this rule, employees could never change to a spouse's plan if the spouse's plan had a different plan year without paying for dual coverage or going uninsured for some period of time.

MEDICARE

8. An employee is becoming eligible for Medicare this year. Can they change their elections when that occurs or will they have to maintain dual coverage until the next open enrollment?

The regulations allow an employee to make a mid-year election change to drop the employer plan upon entitlement to Medicare or Medicaid.

FMLA

9. How does a plan administrator treat employees who take FMLA leave?

FMLA leave allows an employee to either revoke or continue health coverage. If an employee elects to continue health coverage, employee contributions can be prepaid, "pay-as-you-go," or paid after returning from leave. If an employee opts to discontinue coverage (or doesn't pay premiums, depending on the arrangement), the employee upon returning from leave has a right to be reinstated in the plan at the same terms as when leave began.

Administrative Guidelines Created August 1, 2019

Administrative Guidelines Updated August 9, 2021

Administrative Guidelines Updated February 18, 2022

Administrative Guidelines Updated January 24, 2024

Additional Information and References

Below is a snapshot of who to go to for the various scenarios.

Request	Notes
Provider list	<u>Anthem</u> Website: www.anthem.com/ca/prism Customer Service Phone Number: 800-967-3015 Blue Shield Website: www.blueshieldca.com/prism Customer Service Phone Number: 855-256-9404 Kaiser Website: www.kp.org Customer Service Phone Number: 800-464-4000 Express Scripts Website: www.express-scripts.com Customer Service Phone Number: 877-554-3091 Delta Dental Website: www.deltadentalins.com Customer Service Phone Number: 800-765-6003 VSP Website: www.vsp.com Customer Service Phone Number: 800-877-7195 VOYA Website: www.voya.com Basic Life and AD&D Customer Service Phone Number: 888-238-4840 Short-Term Disability and Long-Term Disability Customer Service Phone Number: 888-305-0602 Concern (EAP)

	Website: employees.concernhealth.com Customer Service Phone Number: 800-344-4222
Open Enrollment packages	SDRMA will provide via email
OE Giveaways/Carrier Representation	If your agency has over 100 employees SDRMA upon written request can ask carriers to send giveaways and/or if carrier can be present at your agency's Open Enrollment fair
Renewal	SDRMA sends updated Health Benefits brochure that includes rates via email to participating agencies. Participating Agencies automatically renew unless agency informs SDRMA with a 90-day withdrawal notice as outlined in SDRMA MOU.
Enrollment and Retro Requests	Submit enrollments and retro requests to SDRMA. SDRMA will send retro requests to PRISM for final approval
Escalated Claims Issues	SDRMA
Premium Billing Questions	SDRMA

Contacts

SDRMA Health Benefits Contacts

	<i>Email/Website</i>	<i>Phone</i>
<i>SDRMA Health Benefits Email</i>	healthbenefits@sdrma.org	800-537-7790
<i>SDRMA Health Benefits portal</i>	www.sdrma.org	

Definitions: Pharmacy Program

This section is designed to help agencies navigate and understand complicated Pharmacy Benefit Manager (PBM) terminology.

Express Scripts Pharmacy References: Pharmacy plans that are administered by Express Scripts are as follows and would apply as appropriate below: Blue Shield PPO, EPO and HMO plans. Anthem PPO and EPO plans.

Kaiser HMO, Blue Shield HDHP, Anthem HDHP & HMO pharmacy benefits are administered by the medical carrier's preferred pharmacy vendor (PBM)

Accredo: An Express Scripts specialty pharmacy.

Accredo clinical days' supply: Accredo has in place clinically based recommended days' supply rules for the various medicines within the specialty offering. These rules are put in place to ensure appropriate drug use and to decrease waste of high-cost drugs.

Acute medication: Drugs taken for a limited time to treat temporary medical conditions or illnesses, such as antibiotics for infections.

Appeal: A review of an initial or first-level appeal denial, along with any additional information provided or available, to determine if the participant's use of the drug meets the Plan's intent for coverage. Appeals are related to coverage denials; they are not related to procedures addressing participant complaints or grievances. Express Scripts completes appeals according to business policies that are aligned with state and federal regulations.

Appeals process: A specific process that a participant needs to follow when making an appeal request. Depending on the appeal type, decisions are made by an Express Scripts pharmacist, physician, panel of clinicians, trained prior authorization staff or an independent third-party utilization management company. Participants are notified of the decision and of any rights to appeal an adverse benefit decision.

Benefit exclusion: Also referred to as "not covered," this includes a drug or drug class that is not included in the participant's benefit and means there are no alternatives to try or exceptions to coverage.

Biosimilar: A biopharmaceutical drug designed to have active properties similar to one that has previously been licensed.

Brand: A drug protected by a patent, which prohibits other companies from manufacturing the drug while the patent is in effect, issued to the original innovator or marketer and manufactured by a single source. The name is unique and usually does not describe the chemical makeup (for example, Tylenol®).

In copay and pricing terms, a brand is classified as a non-generic drug that can be multi-source or single-source, as defined below:

- **Multi-source brand:** Available from multiple sources — generally the brand originator and generic manufacturers
- **Single-source brand:** Patent-protected and available from only one source

Compound: A medicine that's made of two or more ingredients that are weighed, measured, prepared, or mixed according to a prescription order.

Controlled Substance: Federal Legend Drug that has potential to cause addiction or abuse.

Copay/coinsurance: The cost of a covered drug paid by the participant at the time the prescription is filled and after the deductible is met (if applicable) per individuals or families.

Copay assistance: For specialty medications filled through Accredo, an Express Scripts specialty pharmacy, the Contact Center and Patient Access teams work with patients to identify and address the need for financial assistance. Express Scripts works with more than 130 copayment programs and continually strives to find more ways to assist participants.

Coverage review: Also known as the initial review or initial determination, this process is followed when a participant requests coverage for a drug, or requests coverage for a drug at a higher benefit. It's the first review of drug coverage based on the Plan's conditions of coverage. The initial review decision is based on the information provided by the prescriber (clinical) or the patient (administrative) and the criteria in place. If the initial review is denied, then the patient/representative may appeal the decision.

Data sharing: The Plan authorizes certain data to be used in data analysis initiatives at Express Scripts. Express Scripts processes more than a billion prescriptions annually for tens of millions of Americans and has extensive experience integrating eligibility and PBM data with medical claims and lab data on behalf of its clients and their medical carriers. This data analysis enables Express Scripts to help identify and make relevant opportunities actionable for participants, caregivers, and providers and to help deliver enhanced participant safety, cost savings and participant service.

Excluded: Drugs that are not covered and will not be reimbursed by the Plan's pharmacy benefit.

Formulary: A preferred list of drug products that typically limits the number of drugs available within a therapeutic class for purposes of drug purchasing, dispensing and/or reimbursement. Products are selected on the basis of safety, efficacy and cost. For more information, refer to Formulary.

Formulary exclusions: Certain drugs are excluded from the formulary. Clinically effective alternatives are available for all excluded products.

Formulary exclusion exception review: The prescriber may request an exception to the formulary exclusion. Express Scripts contacts the prescriber for information to determine if the conditions of coverage are met for an exception to the formulary exclusion. If the formulary exception is denied, the patient or their representative may appeal the decision.

Generic: A drug that has the same active ingredients in the same dosage form and strength as its brand-name counterpart. The color and shape may differ between the generic and brand-name drug; however, the active ingredients must be the same for both. The U.S. Food and Drug Administration (FDA) approves both brand-name and generic drugs and requires generics to have the same active ingredients and be absorbed in the body the same way as brand-name drugs. These requirements assure that generic drugs are as safe and effective as brand-name drugs. Generic drugs often cost less than brand-name drugs. A generic drug can be produced once the manufacturer of the brand-name drug is required to allow other manufacturers to produce the drug.

Home delivery: A distribution channel in which the participant receives a prescription drug through the mail from the Express Scripts PharmacySM.

Maintenance medication: Drugs taken over an extended period of time for a long-term condition, such as high blood pressure, depression, or asthma. These drugs are typically filled through the home delivery pharmacy for a 90 days' supply to provide participants with lower costs and more convenience.

Maximum allowable cost: A Maximum allowable cost or MAC list generally refers to a payer or PBM-generated list of products that includes the upper limit or maximum amount that a plan will pay for generic drugs and brand name drugs that have generic versions available (multi-source brands). Essentially, no two MAC lists are alike and each PBM picks and chooses products for their MAC lists, using different criteria to derive and apply prices to the list. Some of the factors that PBMs consider to choose products for inclusion on a list are availability of the product in the marketplace, whether the product is obtainable from more than one manufacturer, how the product is rated by the FDA in relation to the innovator drug and price differences between the brand and generic products. However, there is no standardization in the industry as to the criteria for the inclusion of drugs on MAC lists or for the methodology as to how the maximum price is determined, changed, or updated.

National Pharmacy & Therapeutics Committee: The National Pharmacy & Therapeutics (P&T) Committee, a fully independent body that makes final formulary determinations, comprises 15 independent physicians and one independent pharmacist who are not employed by Express Scripts. This committee reviews clinical information (formulary evaluation, place in therapy, and competitive product category overviews) for medications newly approved by the FDA. It focuses on clinical considerations.

The P&T Committee meets six times per year. If necessary, mail ballots may be used to seek committee member comments and approval for new clinical designations between meetings—for example, following Food and Drug Administration (FDA) approval of a therapeutic-breakthrough drug.

Network pharmacy: A pharmacy (also called a retail network pharmacy) that participates in the Plan's network. In most cases, participants need to use a network pharmacy to pay the amounts specified by the Plan.

Non-network pharmacy: A pharmacy not associated with the retail network. Benefits will not be covered at the same rate as a network pharmacy and participants will have to pay the full cost of the medication at non-network pharmacies.

Not covered: Also known as “benefit exclusion,” this includes a drug or drug class that is not included in the participant’s benefit, which means there are no alternatives to try or exceptions to coverage.

Over the counter (OTC): A drug that’s available without a prescription from a doctor.

Participating pharmacy: Any licensed retail pharmacy with which Express Scripts (or its affiliates) has executed an agreement to provide covered drugs to participants. This does not include any home delivery or specialty pharmacy affiliated with that participating pharmacy. Participating pharmacies are independent contractors of Express Scripts.

Pharmacy benefit manager (PBM): An information-based, clinically oriented service organization that manages prescription benefits for other organizations. PBM services can include contracting with a network of pharmacies; establishing payment levels for provider pharmacies; negotiating rebate arrangements; developing and managing formularies and preferred drug lists for the Plan’s review and selection; maintaining patient compliance programs; performing drug utilization review; and operating disease management programs. Many PBMs also operate home delivery pharmacies. Express Scripts is your Plan’s PBM.

Pharmacy network: Groups of chain and independently owned pharmacies that contract with a claims processor or plan administrator to provide medicine and pharmacy services to participants at a preset price.

Plan design: The elements of pharmacy benefits, such as drugs covered, participant costs, limitations, and conditions of benefit coverage under the Plan and permitted locations for obtaining covered drugs. Express Scripts manages plan design components as determined by the Plan.

Prescription drug – according to the FDA:

- Prescribed by a doctor
- Bought at a pharmacy
- Prescribed for and intended to be used by one person
- Regulated by FDA through the New Drug Application (NDA) process. This is the formal step a drug sponsor takes to ask that the FDA consider approving a new drug for marketing in the United States. An NDA includes all animal and human data and analyses of the data, as well as information about how the drug behaves in the body and how it is manufactured.

According to Wikipedia: A prescription drug (also prescription medication or prescription medicine) is a pharmaceutical drug that legally requires a medical prescription to be dispensed.

Prescription drug covered expense: Services provided within a given health or pharmacy care plan. Health care and drug benefit services provided or authorized by the payer's Medical Staff or payment for health care services.

Prescription drug plan (PDP): A stand-alone plan, covering only prescription drugs.

Rebate: Money received from certain drug manufacturers as a result of the inclusion of those manufacturers' branded products on the formulary.

Specialist pharmacist: An Express Scripts pharmacist who receives extra training in medicines used to treat specific long-term and complex conditions. These pharmacists use nationally accepted, evidence-based procedures and work with physicians to identify gaps in care across different providers. Specialist pharmacists personally counsel patients to help them understand and follow through on their treatments.

Specialty drug: A high-cost drug, including infused or injectable medicines, that usually require close monitoring and special storage. Specialty drugs are generally prescribed to people with an ongoing or complex medical condition.

Split fill: An Accredo program that divides the copay into four breaks, using the standard day breaks of 1-15, 16-30, 31-60 and 61-90 (alternative day breaks are available). The standard for 1-15 days' copay is 1/6 of the standard copay. This is part of the clinical days' supply program.

Therapeutic Resource Center[®] (TRC): Through personalized care delivered by experienced specialist pharmacists within TRCs, Express Scripts improves patient safety, essential medication adherence and the affordability of drug regimens by closing important gaps in care and optimizing therapies for participants with long-term conditions.

Tiers: The level of coverage for each drug, for example, generic drug tier, brand drug tier or specialty drug tier. The coinsurance or copayment will depend on which tier the drug is in — with lower tier drugs typically costing less than higher tier drugs.

Definitions: Medical

Adjudication: Refers to the process of paying claims submitted or denying them after comparing claims to the benefit or coverage requirements.

Administrative Services Only (ASO): An arrangement under which an insurance carrier or an independent organization will, for a fee, handle the administration of claims, benefits and other administrative functions for a self-insured group but does not assume any financial risk for the payment of benefits.

Balance bill: The amount you could be responsible for (in addition to any co-payments, deductibles, or coinsurance) if you use an out-of-network provider and the fee for the particular service exceeds the allowable charge. Refers to the leftover sum that a provider bills to the patient after insurance has only partially paid the charge that was initially billed.

Calendar Year Deductible: The dollar amount for covered services that must be paid during the calendar year (January 1 – December 31) by participants before any benefits are paid by the Plan.

Centers of Medical Excellence (CME): Health care providers designated as a selected facility for specified medical services. Providers participating in a CME network have an agreement to accept an agreed upon amount as payment in full for covered services.

Coinsurance: An arrangement under which the participant pays a fixed percentage of the cost of medical care after the deductible has been paid. For example, an insurance plan might pay 80% of the allowable charge, with the participant responsible for the remaining 20%, which is then referred to as the coinsurance amount.

Condition Care: Helps promote and improve the overall health status and quality of life of participants and helps promote and/or prevent disease progression and avoid and/or prevent the complications associated with the conditions.

Coordination of Benefits: This is the process by which a health insurance company determines if it should be the primary or secondary payer of medical claims for a patient who has coverage from more than one health insurance policy.

Co-Payment: A specific charge that a health plan may require a participant to pay for a specific medical service or supply, after which the insurance company pays the remainder of the charge.

Deductible: An amount the covered person must pay before payments for covered services begin. The deductible is usually a fixed amount. For example, an insurance plan might require the insured to pay the first \$250 of covered expense during a calendar year.

Dependent: Person, (spouse or child), other than the subscriber who is covered under the subscriber's benefit certificate.

Employee Assistance Program (EAP): A program that is designed to assist in the identification and resolution of productivity problems associated with personal concerns of employees. The program provides employees and their dependents with access to confidential, short-term counseling by qualified practitioners, in person or over the phone.

Explanation of Benefits (EOB): A form sent to the covered person after a claim for payment has been processed by the carrier that explains the action taken on that claim. This explanation might include the amount that will be paid, the benefits available, reasons for denying payment, or the claims appeal process.

Flexible Spending Account: Accounts that let workers set aside pre-tax money from their paycheck toward premiums or costs not covered by their health plan, such as co-payments. All the money must be used within the plan year, or it is lost.

Health Assessment: More agencies are asking workers to fill out such assessments, which give health improvement tips. Agencies can give workers financial incentives to do so.

Health Insurance Portability and Accountability Act (HIPAA): A federal health benefits law passed in 1996, effective July 1, 1997, which among other things, restricts pre-existing condition exclusion periods to ensure portability of health-care coverage between plans, group and individual; requires guaranteed issue and renewal of insurance coverage; prohibits plans from charging individuals' higher premiums, co-payments, and/or deductibles based on health status.

Health Maintenance Organization (HMO): A plan that offers a wide range of health care services through a network of providers who agree to provide services to participants at a pre-negotiated rate. Participants of an HMO choose a primary care physician who will provide most of the health care and refer participants to HMO specialists as needed.

Health Savings Account: A tax advantaged savings account to be used in conjunction with certain high-deductible (low premium) health insurance plans to pay for qualifying medical expenses, such as deductibles. Contributions may be made to the account on a tax-free basis. Funds remain in the account from year to year and may be invested at the discretion of the individual owning the account. Interest or investment returns accrue tax-free. Penalties may apply when funds are withdrawn to pay for anything other than qualifying medical expenses. Employers can also fund such plans.

ID Card/Identification Card: A card issued by a carrier to a covered person, which allows the individual to identify himself or his covered dependents to a provider for health care services. The card is subsequently used by the provider to determine benefit levels and to prepare billing statement.

IBNR: An acronym for "incurred but not reported". This is an accounting estimate used by health plans to accrue for care that was provided "incurred" in one accounting period, but not paid or "reported" until another accounting period.

In-Network: Refers to the use of providers who participate in the carrier's provider network. Many benefit plans encourage covered persons to use participating (in-network) providers to reduce the individual's out of pocket expense.

Medical Tourism: To have medical care outside the United States.

Medigap: Refers to various private health insurance plans sold to supplement Medicare.

Negotiated Rate: The amount participating providers agree to accept as payment in full for covered services. It is usually lower than their normal charge. Negotiated rates are determined by Participating Provider Agreements.

Open Enrollment: A time period during which eligible participants can select among the plans offered by their employer as well as make any other dependent changes.

Out-Of-Network: The use of health care providers who have not contracted with the carrier to provide services. Participants are generally not reimbursed if they go out-of-network except in emergency situations.

Out-Of-Pocket: The most a participant would pay for covered medical expenses in a plan year through copays, deductibles, and coinsurance before your insurance plan begins to pay 100 percent of the covered medical expense.

Participating Provider: A physician, hospital, pharmacy, laboratory or other appropriately licensed provider of health care services or supplies, that has entered into an agreement with a managed care entity to provide such services or supplies to a patient enrolled in a health benefit plan.

Pre-Authorization: A procedure used to review and assess the medical necessity and appropriateness of elective hospital admissions and non- emergency outpatient services before the services are provided.

Preferred Provider Organization (PPO): A type of managed care organization that has a panel of preferred providers who are paid according to a discounted fee schedule. The enrollees do have the option to go to out-of-network providers at a higher level of cost sharing.

Reasonable and Customary: This refers to the standard or most common charge for a particular medical service when rendered in a particular geographic area. Also known as Usual, Customary and Reasonable (UCR).

Skilled Nursing Facility: An inpatient healthcare facility with the staff and equipment to provide skilled care, rehabilitation and other related health services to patients who need nursing care, but do not require hospitalization.

Subscriber: The individual in whose name a contract is issued, or the employee/retiree covered under an employer's group health contract.

Transparency: The ability for patients to have easy access to understandable information about the cost and quality of their health care options. They should be able to obtain this information from their health plan and medical providers prior to the time of treatment.