



NOTICE OF PUBLIC HEARING

PLEASE TAKE NOTICE THAT on **July 30, 2008**, at 2:00 pm in the Board Room at the Department of Community Health, #2 Peachtree Street, 40th Floor, Atlanta, Georgia, a public hearing will be held for the presentation of proposed administrative rule changes.

The chapter affected by the proposed rule & regulation changes is listed below:

Ga. Admin. Comp. Ch. 111-4-1, State Health Benefit Plan

111-4-1-.02 Organizations

111-4-1-.04 Eligibility For Coverage

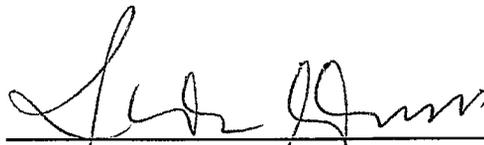
111-4-1-.10 Plan Benefits

All interested persons are hereby given the opportunity to participate by submitting data, views or arguments (orally or in writing). Oral comments may be limited to 10 minutes per person. If you need auxiliary aids or services because of a disability, please contact the Office of General Counsel at (404) 656-4297 at least (3) three business days prior to the hearing.

Written comments must be submitted to the Department or postmarked no later than the close of business at 5:00 p.m. on July 31, 2008. Comments may be faxed to (404) 463-5025, emailed to pjohnson@dch.ga.gov or mailed to the address above, attention General Counsel Division.

Unless revision of the proposed rule changes is indicated as a result of the public comments, it is the intent of the Department of Community Health to ask the Board of Community Health to approve the rule(s) as promulgated herein for final adoption at the next scheduled meeting of the Board in August.

This 19th day of June, 2008.



Rhonda Medows, M.D.

RM:pmj

Attachments

**Rule 111-4-1-.02
Organizations**

Rule 111-4-1-.02(2)(e)

SYNOPSIS

The purpose of the rule change is to modify when Enrolled Member Deduction/ Reduction amounts are due to be presented to the Board.

EXPLANATION OF CHANGES

Rule 111-4-1-.02(2)(e) has been modified to reflect the fact that SHBP plan years now run on calendar year, as opposed to the State Fiscal year. When the plan year changed to a calendar year, the change did not affect the timing of determining Employer Contribution Rates but did affect the timing in determining the Enrolled Member Deduction/Reduction amounts for each Option and Tier, which are based on the plan year. Presenting the Enrolled Member Deduction/Reduction rates at least 90 days before the beginning of the SHBP plan year will ensure these rates are available in time for Open Enrollment.

Rule 111-4-1-.02(3)

SYNOPSIS

The purpose of the rule change is to clarify that the Employing Entity is responsible for statements made by its staff or any third party representing the Employing Entity.

EXPLANATION OF CHANGES

Rule 111-4-1-.02(3) has been modified to clarify that Employing Entities will be responsible for statements to employees made by third parties they have hired or contracted with to represent them. The Employing Entities are making widespread use of third party "enrollment" consultants to assist their employees as they enroll for all benefits, including health. SHBP has encountered numerous situations where the consultant has provided information that conflicted with the SHBP regulations and the employing entity expects SHBP to make exceptions based on the third party's statement.

Rule 111-4-1-.02(3)(h)

SYNOPSIS

The purpose of the rule change is to eliminate paragraph (3)(h).

EXPLANATION OF CHANGES

Rule 111-4-1-.02(3)(h) was inserted in anticipation of having electronic enrollment availability, which did not materialize. The existing Paragraph (3)(g) covers the current method that is being utilized.

111-4-1-.02 Organizations.

(1) **Functions, Duties and Responsibilities of the Board of Community Health.** The Board shall provide policy direction for the operation of the State Health Benefit Plan. Other responsibilities as defined by law are:

(a) **Establish and Design Plan.** The Board is authorized to establish a Health Insurance Plan for group medical insurance against the financial costs of hospitalizations and medical care. The Plan may also include, but is not required to include, prescription drugs, prosthetic appliances, hospital inpatient and outpatient Benefits, dental Benefits, vision care Benefits, and other types of medical Benefits. The Plan shall be designed to:

1. Provide reasonable hospital, surgical, and medical benefits with cost sharing of expenses for each such type to be incurred by the Enrolled Members, Dependents and the Plan;
2. Include reasonable controls, which may include deductible and reinsurance provisions applicable to some or all of the benefits, to reduce unnecessary utilization of the various hospital, surgical and medical services to be provided and to provide reasonable assurance of financial stability in future years of the Plan; and

(b) **Promulgate Regulations.** The Board is authorized to adopt and promulgate rules and regulations for the effective administration of the SHBP; to adopt and promulgate regulations for defining the contract(s) for Retiring Employees and their Spouses and Dependent children; to adopt and promulgate regulations for prescribing the conditions under which an Employee or Retiring Employee may elect to participate in or withdraw from the SHBP; to adopt and promulgate regulations defining the conditions for covering the eligible Member's Spouse and Dependent children and for discontinuance and resumption by eligible Members of Coverage for the Spouse, Surviving Spouse, and Dependents; to adopt and promulgate regulations to establish and define terms and conditions for former and terminated eligible Member participation; adopt and promulgate rules and regulations which define the conditions under which eligible Members who originally rejected Coverage may acquire Coverage at a later date; and adopt and promulgate rules and regulations for withdrawing from the SHBP upon eligibility for the aged program of the Social Security Administration. Additionally, the Plan shall be required to establish the same eligibility requirements, unless either State or federal law, or regulations promulgated by the State of Georgia's Insurance Commissioner requires a modification.

(c) **Establish Member Premium Rates.** The Board shall establish Member Premium Rates for each Coverage Option. The Board shall consider the actuarial estimate of the SHBP costs and the funds appropriated to the various departments, boards, agencies, and school systems in establishing the Employee Deduction amount. Other Member Premium amounts shall be established in accordance with these regulations. All Enrolled Member Premium Rates shall be established by resolution and shall remain in effect until changed by resolution.

1. **Tobacco Surcharge.** An Enrolled Member may be charged a tobacco surcharge in an amount approved by the Board if either the Enrolled Member or any of his or her Covered Dependents have used tobacco products in the previous twelve (12) months. The surcharge amount will be added to the Enrolled Member's base monthly Premium. Any Enrolled Member who fails to answer any designated question(s) relating to the surcharge during Open Enrollment will automatically be charged a surcharge for the remainder of the Plan Year, unless the tobacco

user successfully completes a tobacco cessation program, or other similar program, specifically designated by the SHBP.

2. **Spousal Surcharge.** An Enrolled Member may be charged a spousal surcharge in an amount approved by the Board if the Enrolled Member elects to cover his or her Spouse and the Spouse is eligible for health benefits through his or her employer but opts not to take those benefits. Notwithstanding the foregoing, if the Spouse is already eligible for Coverage with the SHBP through his or her employment, and the Spouse answered the surcharge question(s) on-line, the SHBP will not add the surcharge to the Premium amount. Any Enrolled Member who fails to answer any designated question(s) relating to the surcharge during Open Enrollment will automatically be charged the surcharge for the remainder of the Plan Year.

(d) **Establish Employer Rates.** The Board shall establish by Resolution, subject to the Governor's approval, Employer Contribution Rates. These rates may be a dollar amount for each Member, a dollar amount for each Enrolled Member, a percentage of Member salary or any other method permitted by law.

1. The Employer Contribution Rate for Teachers who retired prior to January 1, 1979 shall be a dollar amount as identified in the Appropriations Act.

2. The State Department of Education Employer Contribution Rate for the Public School Employee Health Insurance Fund shall be a dollar amount as identified in the Appropriations Act.

3. The local school system Employer Contribution Rate for the Public School Employee Health Insurance Fund shall be a dollar amount per Enrolled Member and shall be remitted to the Administrator on a monthly basis. The Employer's Contribution amount shall be due to the Administrator on the first of the month coincident with the Employees' monthly Premium amounts. The Commissioner is authorized to establish necessary procedures to implement the receipt of the Employer Contribution on a timely and accurate basis.

4. The Employer Contribution Rate for the Teachers Health Insurance Fund shall be a percentage of the salary approved by the State Board of Education under the Quality Basic Education Act for persons holding "Certificated Positions" or in a "Certificated Capacity". The monthly Employer Contribution shall be a percentage of state based salaries. County or district libraries shall pay as the Employer Contribution the Board approved percentage of total salaries, exclusive of per diem and casual labor, which is defined as part-time Employees who work less than seventeen and a half (17 ½) hours per week. The Employer's contribution amount shall be due to the Administrator on the date coincident with the Employees' monthly Premium amounts. The Commissioner is authorized to establish necessary procedures to implement the receipt of the Employer Contribution on a timely and accurate basis.

5. The Employer Contribution Rate for the State Employees Health Insurance Fund shall be a percentage of the total salaries of all Members. Total salaries include temporary salaries, overtime pay, terminal leave pay, and all types of supplemental pay. The monthly Employer Contribution shall be based on salaries for the previous month and shall be due on the date coincident with the Employees' monthly Premium amounts. The Commissioner is authorized to establish necessary procedures to facilitate the receipt of the Employer Contribution on a timely and accurate basis.

(e) **Approve Contracts.** The Board is authorized to approve contracts for insurance, reinsurance, health services and administrative services for the operation of the Plan. The Board shall also approve contracts to include HMOs and Consumer Driven Health Plans ("CDHP") as

an alternative to Regular Insurance and approve contracts as authorized by law with governments, authorities, or other organizations for inclusion in the Plan.

1. **Insurance.** The Board may execute a contract or contracts to provide the Benefits under the Plan. Such contract or contracts may be executed with one or more corporations licensed to transact accident and health insurance business in Georgia. The Board shall invite proposals from qualified insurers who, in the opinion of the Board, would desire to accept any part of the health benefit Coverage. Any contracts that the Board executes with insurers shall require compliance with O.C.G.A. § 10-1-393 (b)(30.1) relating to certain unfair practices in consumer transactions. The Board may reinsure portions of a contract for the Plan. At the end of any contract year, the Board may discontinue any contract or contracts it has executed with any corporation or corporations and substitute a contract or contracts with any other corporation or corporations licensed to transact accident and health insurance business in Georgia.

2. **Self Insurance.** The Board in its discretion may establish a self-insured Plan in whole or in part. The contract for Administrative Services in connection with a self-insured health benefit plan may be executed with an insurer authorized to transact accident and sickness insurance in Georgia; with a hospital service nonprofit corporation, nonprofit medical service corporation, or health care corporation; with a professional claim Administrator authorized or licensed to transact business in Georgia; or with an independent adjusting firm with Employees who are licensed as independent adjusters pursuant to Article 2 of Chapter 23 of Title 33.

3. **Local Governments.** The Board is authorized to contract with the various counties of Georgia, the County Officers Association of Georgia, the Georgia Cooperative Services for the Blind, public and private nonprofit sheltered employment centers which contract with or employ persons within the Division of Rehabilitation Services and the Division of Mental Health and Mental Retardation of the Department of Human Resources; and to contract with the Georgia Development Authority, the Georgia Agrirama Development Authority, the Peace Officer's Annuity and Benefit Fund, the Georgia Firefighters' Pension Fund, the Sheriffs' Retirement Fund of Georgia, the Georgia Housing and Financing Authority, the Georgia-Federal State Inspection Service for the inclusion of eligible Members, retiring Enrolled Members and Dependents in the SHBP. The Board is further authorized to include the Georgia-Federal State Inspection Service Employees who retired under the Employees' Retirement System of Georgia on or before July 1, 2000. Each Contract Employer shall deduct from the Enrolled Members salary the Member's cost of Coverage. In the case of the Georgia Development Authority, the Peach Officers' Annuity and Benefit Fund, the Georgia Firefighters' Pension Fund, the Sheriffs' Retirement Fund of Georgia, the Georgia Housing Authority, and the Georgia Agrirama Development Authority, the Retiree's cost of Coverage shall be deducted from the Retired Enrolled Member's annuity payment. In addition, each Contract Employer shall make the Employer Contribution required for inclusion in the Plan and remit such payments in accordance with procedures as the Administrator may require.

4. **Consumer Driven Health Plans (CDHPs).** The Board may contract with any CDHP qualified and licensed to conduct business in Georgia pursuant to Chapter 21 of Title 33 of the Official Code of Georgia Annotated.

5. **Other Organizations.** The Board is authorized to contract with other organizations, including any public or nonprofit critical access hospital, and any federally qualified health center as defined in 42 U.S.C.A. 1395x(aa)(4), that meets such requirements as the Administrator may establish for the inclusion of eligible Members and Dependents in the SHBP. Each Contract Employer shall deduct from the Enrolled Member's salary the Member's share of the cost of

Coverage. Each Employer shall remit the total Premium amount as established by the Administrator for inclusion of its Members in the Plan and in accordance with such procedures as the Administrator may require.

(i) **Coverage Termination for Failure to Remit Premiums.** Upon providing written notice, the Commissioner may terminate Coverage for any Group that either contracts for SHBP Coverage or is designated by applicable state law as eligible for such Coverage for failure to remit either Employee or Employer Contributions.

(ii) **Reinstatement of Coverage.** Upon remittance of the required contributions from any Group that either contracts for SHBP Coverage or is designated by applicable state law as eligible for such Coverage, the SHBP may reinstate Coverage that has been terminated previously for failure to remit Premiums.

(iii) **Bond.** The Board may require that specified Groups provide a bond to ensure payment performance before allowing SHBP Coverage.

6. **Health Maintenance Organizations (HMOs).** The Board may contract with any HMO qualified and licensed to conduct business in Georgia pursuant to Chapter 21 of Title 33, relating to Health Maintenance Organizations.

7. **Local School Systems.** When a school system has elected not to participate in the SHBP for Public School Employees, the Employees may petition the local school system to contract with the Board for an Employee-Pay-Group. The local system may contract with the Board after agreeing to:

(i) Collect the Enrolled Member Premium amounts for the Rates established by the Board; and

(ii) Enroll and maintain enrollment at 75% of the eligible Public School Employees as defined in these regulations.

(2) **Functions, Duties and Responsibilities of the Commissioner.** The Commissioner is the chief administrative officer of the Department of Community Health. The Commissioner and Administrator as used in these regulations are synonymous. The Commissioner shall employ such personnel as may be needed to administer the SHBP, to appoint and prescribe the duties of positions, all positions of which shall be included in the classified service except as otherwise provided in the law, and may delegate administrative functions and duties at the Commissioner's discretion.

(a) **Administer Regulations and Policies.** The Commissioner shall administer the SHBP consistent with Board regulation and policy.

(b) **Custodian of Funds.** The Commissioner shall be the custodian of the health benefit Funds and shall be responsible under a properly approved bond for all monies coming into said Funds and paid out of said Funds.

1. All amounts contributed to the Funds by the Member and the Employers and all other income from any source shall be credited to and constitute a part of such trust Funds. Any amounts remaining in such Fund(s) after all expenses have been paid shall be retained in such Fund(s) as a special reserve for adverse fluctuation.

2. The Commissioner shall establish accounting procedures for maintaining trust Funds for the Premium income, interest earned on the income and expenses and benefits paid. Any amounts remaining in each trust Fund after all expenses have been paid shall be retained wholly for the benefit of the members who are eligible and who continue to participate in each health insurance trust.

3. The Commissioner shall submit to the Director of the Office of Treasury and Fiscal Services any amounts available for investment, an estimate of the date such Funds shall no longer be available for investment, and when Funds are to be withdrawn. The director of the Office of Treasury and Fiscal Services shall deposit the Funds in a trust account for credit only to the Plan and shall invest the Funds subject only to the terms, conditions, limitations and restrictions imposed by the laws of Georgia upon domestic life insurance companies.

4. The Commissioner may administratively discharge a debt or obligation not greater than \$400.00 due the Health Insurance Fund or Funds.

(c) **Regulations.** The Commissioner shall recommend to the Board amendments to the regulations, submit the approved regulations to appropriate filing entities, cause all regulations to be published and provide a copy to the Employing Entities.

(d) **Elicit and Evaluate Proposals from Health Care Contractors and/or Administrators.** As required for the appropriate administration of the Plan, the Commissioner shall cause to be prepared requests for proposals for selection of health care contractors, vendors, or administrators. Upon receipt of the proposals, the Commissioner shall secure an evaluation of the proposals and submit recommendations for the selection of health care contractors, vendors, or administrators to the Board for approval.

(e) **Calculate Employer Contribution Rate.** The Commissioner shall cause to be calculated an average Employer Contribution Rate for each Tier non-Medicare Advantage Enrolled Members based on the method specified in Section 111-4-1-.02(d)(1)-(5) of these regulations. The Commissioner shall present the Employer HMO Contribution Rates at least sixty (60) days before the beginning of the State of Georgia's Fiscal Year and the Enrolled Member Deduction/Reduction amounts for each Option and Tier to the Board for adoption at least ~~sixty (60)~~ ninety (90) days before the beginning of the SHBP plan year State of Georgia's Fiscal Year.

(f) **Premium Payments to a Contractor.** The Commissioner shall calculate the Premium amounts due to each HMO and to any underwriter of insurance or re-insurance and remit payments from the appropriate trust Funds for Member-Coverage.

(g) **Develop and Publish Plan Document.** The Commissioner shall cause to be developed a Summary Plan Description (SPD) or Certificate of Coverage which incorporates the approved schedule of Benefits, eligibility requirements, Termination of Coverage provisions, Extended Coverage provisions, to whom benefits will be payable, to whom claims should be submitted, and other administrative requirements. The Commissioner or designee shall cause a pre-determined percentage of the SPD's to be printed and distributed to each local and state Employer for distribution to Enrolled Members. The Commissioner or designee shall cause to distribute the SPD to Retired Enrolled Members and Extended Beneficiaries at their last known address.

(h) **Provide Notice of Employer Contribution.** The Commissioner shall provide notice and certification of the required Employer Contribution Rate to each of the Employing Entities and the Department of Education on or before June 1 of each year, if the Rate for the ensuing

fiscal year is to be modified. The Commissioner shall notify the Employing Entities before the Rate is effective of any Rate change which may be required at times other than the beginning of a fiscal year.

(i) **Provide Notice of Eligibility.** The Commissioner shall develop procedures for notifying Extended Beneficiaries of the Extended Coverage provisions of Section 111-4-1-.08 of these regulations upon notification by the Employing Entity of the Enrolled Member's employment termination, death, or reduced hours or upon notification by the Member of divorce, legal separation, or child no longer meeting the definition of Dependent.

(j) **Provide Certification of Creditable Coverage.** The Administrator shall establish procedures for providing a Certificate of Creditable Coverage to each Enrolled Member at the time Coverage cancels or upon request of the Member or Covered Dependent and for a period of twenty-four (24) months after coverage cancellation. The Member may use the certification to limit a subsequent plan's imposition of a Pre-existing Condition limitation or exclusion period. Coverage cancellation may be the result of termination of Coverage through Employee Deduction/Reduction, termination of Coverage at the end of an Approved Leave of Absence Without Pay, or termination of Coverage at the end of the COBRA Extended Coverage period.

(k) **Correction for Administrative Error.** An administrative error is defined as any clerical error in submitting pertinent records or a delay in making any changes by the Employing Entity or Administrator that affects the Coverage for a Member or Dependent who has followed all established procedures and met the time deadlines regarding enrollment or maintenance of Coverage. If the error has placed the Member or Dependent at a substantial financial risk or risk of loss of Coverage, the facts shall be reviewed and corrective action taken. If the Administrator concludes that the Member or Dependent was substantially harmed, the Member or Dependent shall be restored to the former position or shall be granted the request in whole or in part. Any determination of an administrative error shall be left to the discretion of the Administrator and is not subject to challenge.

(3) **Duties and Responsibilities of Employing Entity.** Each Employing Entity is responsible for complying with these regulations. Statements made by the staff of the Employing Entities or any third party representing the Employing Entity, that are in conflict with these regulations, the Schedule of Benefits, Decision Guide, or the Summary Plan Description (SPD) shall not be binding on the Administrator. Failure of the Employing Entities to fulfill the duties and responsibilities listed in these regulations does not negate the time requirements specified throughout these regulations.

(a) **Enroll Eligible Employees.** Each Employing Entity shall instruct and assist all persons who become eligible to become Enrolled Members under these regulations how to complete the SHBP enrollment or declination process. The Employing Entity shall require each eligible new Member to complete, within thirty-one (31) calendar days of reporting to work, a form for enrolling or declining SHBP Coverage. The Employing Entity shall be responsible for collecting any Premiums due for the selected Coverage.

(b) **Deduct Enrolled Member Premium Amounts.** The Employing Entity shall withhold the Enrolled Member Premium amount as approved by the Board, or the Premium amount authorized by the applicable Georgia Code sections, from earned compensation as the Enrolled Member's share of the cost of Coverage under the Plan. Any retirement system under which retired or retiring Enrolled Members may continue Coverage under the SHBP as an

Annuitant shall withhold the Premium amount as approved by the Board from the annuity as the Enrolled Member's share of the cost of Coverage under the Plan.

(c) **Remit Employee and Employer Amounts.** The Employing Entity or retirement system shall reconcile their Enrolled Member's SHBP Coverage records to their payroll records in the manner prescribed by the Administrator. Each Employing Entity and retirement system shall remit within five (5) working days following the effective date of Coverage, an amount equal to the full, face amount of the Premium due for the period coincident with the Enrolled Member's SHBP Coverage, as reflected on the SHBP monthly billing statement. Each Employer is responsible for reconciling the Premium payments and the monthly billing invoice to make any and all corrections to the records prior to the Coverage effective date. This reconciliation is to be done within thirty (30) days of issue of the billing invoice. Each Employing Entity, except for a retirement system, shall remit the Employer Contribution amount to the Administrator for the period coincident with the Enrolled Member's Coverage month within five (5) working days of the due date.

1. The Employing Entity shall calculate and remit the appropriate Employer Contribution including administrative fees, for those Members who elect to enroll or continue Coverage during an approved family medical or Approved Leave of Absence Without Pay.

(d) **Provide Employee Enrollment Information to the Administrator.** Each Employing Entity shall make available to eligible Members all educational and benefit enrollment information necessary for the Member to make an informed health benefit plan.

(e) **Provide Plan Materials to Each Eligible Member.** Each Employing Entity shall distribute the Summary Plan Description and enrollment information to each eligible Member. Each Employing Entity shall make every effort to distribute other SHBP materials, including Open or Special Enrollment information, and information about the web site, to Members at the request of the Administrator. When appropriate, each Employing Entity shall hold group meetings to explain a specific aspect of the SHBP to Members.

(f) **Administer Leave Without Pay Provisions.** Each Employing Entity shall administer Approved Leave of Absence Without Pay and Family and Medical Leave Act Programs in compliance with the federal laws and shall provide information regarding the conditions for continuing Coverage under the SHBP to eligible Enrolled Members. Each Employing Entity shall also provide continuation of Coverage enrollment information to Members. Each Employing Entity shall insure Members on Approved Leave of Absence Without Pay are properly notified of the annual Open Enrollment period and afforded the opportunity to enroll or change Coverage.

(g) **Provide Member Loss of Eligibility Information to the Administrator.** Each Employing Entity shall report to the Administrator the last date employed/eligible and the reason for the loss of employment/eligibility no later than thirty (30) days following the event leading to loss of eligibility to participate in the Plan through payroll Deduction/Reduction. The reasons for loss of eligibility shall be limited to: resignation, transfer, retirement, termination for gross misconduct, separation for reasons other than gross misconduct, reduced employment hours that affect Coverage eligibility, lay-off, leave of absence without pay, discontinuation, and death. Any penalties assessed upon the Administrator for failure to comply with notification requirements of COBRA as a result of the Employing Entity's failure to notify the Administrator shall be billed to the respective Employing Entity. The Employing Entity shall reimburse the

Administrator in full for claim liability and expenditures incurred by the Plan as a result of the Employing Entity's failure to comply with notification requirements.

~~(h) **Provide Member Loss of Eligibility Information to the Administrator.** Each Employing Entity shall report to the Administrator through electronic interface files or data entry into the electronic enrollment web site the last date employed/eligible and the reason for the loss of employment/eligibility no later than thirty (30) days following the event leading to loss of eligibility to participate in the Plan through payroll Deduction/Reduction. The reasons for loss of eligibility shall be limited to: resignation, transfer, retirement, termination for gross misconduct, separation for reasons other than gross misconduct, reduced employment hours that affect Coverage eligibility, lay off, leave of absence without pay, discontinuation, and death. Any penalties assessed upon the Administrator for failure to comply with notification requirements of COBRA as a result of the Employing Entity's failure to notify the Administrator shall be billed to the respective Employing Entity. The Employing Entity shall reimburse the Administrator in full for claim liability and expenditures incurred by the Plan as a result of the Employing Entity's failure to comply with notification requirements.~~

Authority O.C.G.A. §§ 20-2-55, 20-2-881, 20-2-883 to 20-2-885, 20-2-891 to 20-2-896, 20-2-911 to 20-2-916, 20-2-918 to 20-2-922, 20-2-924, 31-5A, 45-18-1 et seq., Health Insurance Portability and Accountability Act (HIPAA), Consolidated Omnibus Budget Reconciliation Act (COBRA), Family Medical Leave Act(FMLA).

**Rule 111-4-1-.04
Eligibility For Coverage**

Rule 111-4-1-.04(6)(f)

SYNOPSIS

The purpose of the rule change is to amend the current regulation regarding military leave to reflect recent changes to Federal law.

EXPLANATION OF CHANGES

Rule 111-4-1-.04(6)(f) is necessary to be in compliance with Section 585 of the National Defense Authorization Act for FY 2008 (NDAA), Pub. L. 110-181. Section 585 of the NDAA amends the Family and Medical Leave Act of 1993 (FMLA) to permit a "spouse, son, daughter, parent, or next of kin" to take up to 26 workweeks of leave to care for a "member of the Armed Forces, including a member of the National Guard or Reserves, who is undergoing medical treatment, recuperation, or therapy, is otherwise in outpatient status, or is otherwise on the temporary disability retired list, for a serious injury or illness." The NDAA also permits an employee to take FMLA leave for "any qualifying exigency arising out of the fact that the spouse, or a son, daughter, or parent of the employee is on active duty (or has been notified of an impending call or order to active duty) in the Armed Forces in support of a contingency operation."

Rule 111-4-1-.04(10)

SYNOPSIS

The purpose of the rule change is to amend the process as it relates to documenting eligibility.

EXPLANATION OF CHANGES

Rule 111-4-1-.04(10) was initially written in anticipation of having electronic enrollment availability, which did not materialize. The regulation resulted in dependents, who were eligible to be covered under SHBP, not having the needed coverage available to them until the next Open Enrollment. A change in the regulation will allow SHBP to grant dependent coverage upon receipt of eligibility documentation rather than waiting for the next Open Enrollment.

Rule 111-4-1-.04(11)

SYNOPSIS

The purpose of the rule is to modify coverage eligibility for Totally Disabled Children after age nineteen (19).

EXPLANATION OF CHANGES

Rule 111-4-1-.04(11) is modified to allow Enrolled Members to apply for coverage, not just continued coverage, of a Totally Disabled Child in accordance with the Americans With Disabilities Act (ADA).

Rule 111-4-1-.04(11)(a)

SYNOPSIS

The purpose of the rule change is to modify when Enrolled Members may apply for coverage for Totally Disabled Children after age nineteen (19).

EXPLANATION OF CHANGE

Rule 111-4-1-.04(11)(a) is modified to allow Enrolled Members to apply for coverage for Totally Disabled Children during Open Enrollment, as a New Hire, or as the result of a Qualifying Event.

Rule 111-4-1-.04(12)(a)

SYNOPSIS

The purpose of the rule change is to update SHBP regulation to be in compliance with Federal Medicare policy.

EXPLANATION OF CHANGES

Rule 111-4-1-.04(12)(a) is necessary to be compliant with Federal Medicare policy. Medicare is primary when the surviving spouse chooses to continue coverage under SHBP and is unemployed. If the surviving spouse is also eligible as an active employee, CMS requires the coverage to be under the active plan (so Medicare will be secondary on all claims). SHBP does not collect a employer contribution on a surviving spouse but is able to if the surviving spouse is covered as an active employee, if eligible.

Rule 111-4-1-.04(12)(b)

SYNOPSIS

The purpose of the rule change is to update SHBP regulation to be in compliance with Federal Medicare policy.

EXPLANATION OF CHANGES

Rule 111-4-1-.04(12)(b) is necessary to be compliant with Federal Medicare policy. Medicare is primary when the surviving spouse chooses to continue coverage under SHBP and is unemployed. If the surviving spouse is also eligible as an active employee, CMS requires the coverage to be under the active plan (so Medicare will be secondary on all claims). SHBP does

not collect a employer contribution on a surviving spouse but is able to if the surviving spouse is covered as an active employee, if eligible.

Rule 111-4-1-.04(13)

SYNOPSIS

The purpose of the rule change is to clarify the process regarding verifying dependent eligibility.

EXPLANATION OF CHANGES

Rule 111-4-1-.04(13) currently contains time limitations for submitting which have excluded dependents solely on the basis of submitting eligibility verification and, when received late, would exclude dependents from coverage. This change would allow SHBP to provide coverage, within the same plan year, whenever the documentation is received. Members who fail to submit appropriate verification will remain in the coverage tier the member originally elected.

111-4-1-.04 Eligibility for Coverage.

(1) **Active Employees.** Employees who are actively at work or on approved leave of absence and have not terminated their employment may participate in the SHBP if classified as the following:

(a) **Full-Time.**

1. State Employees who work a minimum of thirty (30) hours per weeks are considered full-time.

2. A regular full-time Employee who receives a salary or wage payment from a state department, board, agency, commission, the general assembly, a community service board, or a local government or other organization with which the Board of Community Health is authorized to contract; except contingent workers of the Labor Department, specially classified Employees of the Jekyll Island State Park Authority, Employees working as an independent contractor or on a temporary, seasonal, or intermittent basis and Employees whose duties are expected to require less than nine (9) months of service.

3. A regular full-time Employee who receives a salary or wage payment from a state authority that participates in the Employees' Retirement System;

4. Part-time Employees of the General Assembly who had coverage prior to January 1981, and Administrative and clerical personnel of the General Assembly;

5. A full-time district attorney, assistant district attorney who was appointed pursuant to O.C.G.A. § 15-18-14, or district attorneys' investigators appointed pursuant to O.C.G.A. § 15-18-14.1 of the superior courts of this state;

6. A full-time Employee who receives a salary or wage payment from a county board of health or a county board of family and children services that receives financial assistance from the Department of Human Resources; except for sheltered workshop Employees;

7. Full-time secretaries and law clerks who are employed by district attorneys and judges and are employed under O.C.G.A. §§ 15-6-25 through 15-6-28 and O.C.G.A. §§15-18-17 through 15-18-19.

(b) Teachers who are employed not less than half time, which must be at least seventeen and a half (17½) hours per week, in the public school systems of Georgia are eligible to participate under these regulations. An eligible teacher shall not include any independent contractor, emergency or temporary person and is further defined as:

1. A person employed in a professionally Certificated Capacity or Position in the public school systems of Georgia;

2. A person employed by a regional or county library of Georgia;

3. A person employed in a professionally Certificated Capacity or Position in the public vocational and technical schools operated by a local school system;

4. A person employed in a professionally Certificated Capacity or Position in the Regional Educational Service Areas of Georgia;

5. A person employed in a professionally Certificated Capacity or Position in the high school program of the Georgia Military College.

(c) Public School Employees who are employed by a local school system that have elected to participate in the Plan, and are not considered independent contractors, are eligible to enroll under the conditions of these regulations.

1. An Employee who is eligible to participate in the Public School Employees Retirement System as defined by Paragraph (20) of O.C.G.A. § 47-4-2 may enroll, provided the Employee works the greater of at least 60 percent of the time required to carry out the duties of such position or a minimum of fifteen (15) hours per week and is not employed on an emergency or temporary basis.

2. An Employee who holds a non-certificated public school position and who is eligible to participate in the Teachers Retirement System (or other independent local school retirement system), provided the Employee is not employed on an emergency or temporary basis and the Employee works at least 60 percent of the time required to carry out the duties of such position or a minimum of twenty (20) hours per week, whichever is greater may enroll.

(d) **Local Boards of Education** that elect to provide group medical insurance for members of the local board of education, their spouses, and dependents in accordance with O.C.G.A. § 45-18-5 are eligible to enroll under the conditions of these regulations. Collection and remittance of Enrolled Member premium and employer contribution amounts shall be in accordance with O.C.G.A. § 20-2-55 and these regulations.

(2) **Retired Employees.** Any Employee who was eligible to participate under 111-4-1-.04(1)(a), 111-4-1-.04(1)(b), or 111-4-1-.04(1)(c) and who was enrolled in the Plan at the time of retirement shall be eligible to continue coverage if:

(a) The Retired Employee is eligible to immediately receive an annuity from the Employees' Retirement System, Georgia Legislative Retirement System, Judicial Retirement System, Superior Court Judges or District Attorneys' Retirement System, Teachers Retirement System, Public School Employees Retirement System, any local school system teachers retirement system, or other retirement system with which the Board is authorized to contract; or

(b) The Retired Employee as an Employee of a county department of family and children services or a county department of health is eligible to receive an annuity from the Fulton County Retirement System.

(3) **Eligibility for Coverage as an Enrolled Member and a Dependent.** In the situation where both husband and wife are eligible to be covered under the SHBP as an Enrolled Member, each may enroll as a Member and enroll the eligible dependents so that the benefits provided under the SHBP will be coordinated in accordance with the Coordination of Benefits or the Medicare Coordination of Benefits provisions of these regulations. In no case shall the sum of the total benefits provided by the SHBP exceed the reasonable charges for covered services.

(4) **Eligibility for Coverage as an Enrolled Member Limited.** In the situation where the Enrolled Member is entitled to Coverage under the SHBP as an Active Employee under a health insurance act and Retired Employee under a different health insurance act, or any combination of provisions, the Member may choose among the Active Employee provisions under which the Member will be covered, but may not choose Coverage as a Retiree or Beneficiary of a Retiree as long as the Member is eligible for Coverage under one of the Active Employee provisions. In no

circumstance shall the individual be an Enrolled Member under more than one provision of these regulations.

(5) **Eligibility for Coverage as an Active Employee with Two (2) Employing Entities.** Dual eligibility and overlapping Coverage shall be handled as follows:

(a) **Dual Eligibility.** In the situation where the Enrolled Member is eligible for Coverage under the SHBP as an Active Employee of two (2) separate Employing Entities, the Employee may, during the annual Open Enrollment period, elect which Employing Entity shall deduct the Employee Premium in the upcoming Plan Year. Each Employing Entity is responsible for remitting Employer Contribution amounts in accordance with 111-4-1-.02(3)(d) of these regulations.

(b) **Overlapping Coverage.** In the situation where the Enrolled Member experiences a period of overlapping Coverage as a result of transferring employment between two (2) separate Employing Entities, the Coverage effective date with the second Employer shall determine the Coverage termination date with the first Employer. The Employing Entities shall be responsible under this provision for deducting or refunding Employee Premiums as appropriate.

(6) **Employees on Leave Without Pay.** Active Employees who are Enrolled Members of the SHBP may continue the Coverage in which enrolled during a period of "Approved Leave of Absence Without Pay", subject to the conditions in these regulations. Enrolled Employees who are on suspension or Approved Leave of Absence Without Pay who did not continue Coverage shall not be eligible to enroll or re-enroll for Coverage while on Approved Leave of Absence Without Pay under any provision of these regulations except during the annual Open Enrollment period. Except for military leave Coverage shall not be extended for an Employee who is self employed or gainfully employed by another party during a period of Approved Leave of Absence Without Pay. A request to continue Coverage while on Approved Leave Without Pay must be received by the Administrator within thirty-one (31) calendar days of the termination of paid Coverage through payroll Deductions. Employees who qualify for continued Coverage under multiple leave types may continue Coverage under a combination of leave types; however, the total period of Coverage on Approved Leave of Absence Without Pay shall not exceed twelve (12) calendar months, unless otherwise noted in these provisions. Premium payments must be in an amount sufficient to provide continuous Coverage between termination of paid Coverage through payroll Deductions and the beginning of Approved Leave of Absence Without Pay Coverage. When an Employee on Approved Leave of Absence Without Pay enrolls during the annual Open Enrollment, Period the twelve (12) calendar month Coverage period shall be reduced by the number of prior months of Approved Leave of Absence Without Pay during which the Employee did not elect to participate in the SHBP.

(a) **Disability Leave.** A disability leave is the period of time an Approved Leave of Absence Without Pay has been granted to the Employee due to personal illness, accident or disability. Coverage may be continued under this paragraph for the period of disability, but not longer than twelve (12) consecutive calendar months. Certification of the disability period by a licensed physician shall be required to continue coverage under this provision.

(b) **Reduced Working Hours Due to Partial Disability.** A Partial Disability leave is the period of time during which an Employer approves an Employee's return to work on a part-time basis from a period of disability leave or paid leave if the part-time work is part of a process to gradually return the Employee to full-time work. Coverage may be continued under this provision for the period of disability approved by a licensed physician, but not longer than twelve

(12) consecutive calendar months, inclusive of any time from a period of disability leave without pay. Certification of the Partial Disability period shall be required to continue coverage under this provision.

(c) **Leave of Absence for the Employer's Convenience.** Employer's convenience leave is a period of time during which an Approved Leave of Absence Without Pay has been granted by the appropriate organizational official due to a regular programmatic plan for Employee absence and pursuant to appropriate regulation. The Employee may continue the Coverage such leave of absence, but not longer than twelve (12) consecutive calendar months.

(d) **Educational Leave.** Educational leave is the period of time during which an Approved Leave of Absence Without Pay has been granted by the appropriate organizational official for educational or training purposes. The Employee may continue the Coverage under such leave for the period of absence, but not longer than twelve (12) consecutive calendar months.

(e) **Family Medical Leave.** Family medical leave is the period of time during which an Approved Leave of Absence Without Pay has been granted to the Employee by the appropriate organizational official for personal illness, the care of the Employee's child after birth or placement for adoption or the care of an Employee's seriously ill Spouse, child, or parent. An Employee's personal illness, if properly certified and approved may be granted under the disability leave provisions. Coverage while on Approved Leave of Absence Without Pay for family medical leave may be continued for the period of approved leave, but not longer than twelve (12) weeks in any twelve (12) consecutive month period.

(f) **Military Leave.** Military leave is the period of time during which an Approved Leave of Absence Without Pay has been granted by the appropriate organization official when an Employee is ordered to military duty or the period, as provided by law, during which an Employee is attending military training. Military leave also applies to an Employee who qualifies for an exigency leave or service member care leave, as defined under Federal law. The Employee may continue the Coverage under such leave for the period of absence.

(g) **Suspension or Other Leave of Absence.** Suspension or other leave of absence is the period of time during which suspension is in effect or an Approved Leave of Absence Without Pay has been granted by the appropriate organization official for the Employee's convenience. The Employee may continue the Coverage for the period of suspension or approved leave, but not to exceed twelve (12) calendar consecutive months, provided the Employee is not self employed or gainfully employed by another party during such leave of absence.

(h) **Extensions of Leave of Absence.** If the Employee is unable to return to work at the expiration of the approved leave and the maximum period has not been exhausted, a request to extend the leave of absence may be filed. The Administrator must receive the Employee's request for extension no later than thirty-one (31) calendar days following expiration of Coverage under the leave of absence. The Employing Entity must certify approval of the extension. The attending physician must complete a new disability certification for an extension of a disability leave.

(i) **Sequential Periods of Leave.** Health benefits may be continued during sequential types of leave, provided that continuation of health benefits during continuous,

sequential periods of time shall not exceed the time limitation of the most recently approved type of leave.

(j) **Premiums.** Premiums for continued Coverage during a period of Approved Leave of Absence Without Pay shall be paid monthly. When establishing the monthly Premium amount to be paid by the Employee, the Board may add a processing fee. The Premium Rate, excluding the processing fee, shall be based on the type of approved leave. The Premium Rate for disability, family leave or military leave of absence shall be the same as the Employee Deduction; the Premium Rate for all other types of leave shall be the total amount, which consists of the Employee Deduction and average Employer Contribution. Failure to pay the full Premium as billed within the allotted time shall result in termination of Coverage until the first of the month following a payroll deduction for coverage after the Employee returns to work or until all premiums are paid in full if the Employee remains out on leave.

(7) **Spouse.** An Active Employee shall be entitled to enroll the Employee's Spouse upon employment, during Open Enrollment, or under conditions specified in Section 111-4-1-.06 of these regulations. A Retiree shall be entitled to continue Coverage for the Spouse upon retirement or may enroll the Spouse in accordance with Section 111-4-1-.06 (5) or 111-4-1-.06 (6). The Administrator shall require appropriate documentation from an Enrolled Member in order to verify a Spouse's eligibility for Coverage.

(8) **Dependent Child.** An Active Employee shall be entitled to enroll eligible Dependent children upon employment, during Open Enrollment, or under conditions specified in Section 111-4-1-.06 of these regulations. A Retiree shall be entitled to continue Coverage for eligible Dependent children upon retirement or may enroll eligible Dependent children in accordance with Section 111-4-1-.06 (5). The Administrator shall require appropriate documentation from an Enrolled Member in order to verify a Dependent child's eligibility for Coverage. An eligible Dependent child is one who is not married nor has been married, except for a legally accepted annulment, and is:

(a) A natural child, for which the natural guardian has not relinquished all guardianship rights through a judicial decree, for the period from birth to the end of the month in which the child reaches age nineteen (19);

(b) An adopted child for the period from the date of adoption contract. Coverage may be granted from the date of legal physical custody and placement in the home. Coverage ends at the end of the month in which the child reaches age nineteen (19);

(c) A stepchild who resides in the Enrolled Member's home one hundred eighty (180) days or more per year in a parent-child relationship. Eligibility begins on the later of the date of marriage to the natural parent, or the effective date of a custody order resulting in residential custody greater than one hundred eighty (180) days per year. Eligibility ends at the earlier of: the month in which the child turns age nineteen (19), if not a full-time student, the date of the Enrolled Member's divorce from the natural parent, or the effective date of a change in the joint custody order that results in residential custody of less than one hundred eighty (180) days per year; or

(d) Guardianship. A resident in the Enrolled Member's home in a parent-child relationship and is legally certified as a Dependent of the Enrolled Member for financial support until the earlier of the end of the month in which the child reaches age nineteen (19) or the expiration date specified in the court order; provided, however, certification of legal dependency is submitted to

and approved by the Administrator. Certification documentation requirements are at the discretion of the Administrator. However, a judicial decree from a court of competent jurisdiction is required unless the Administrator concludes that documentation is satisfactory to meet the test of legal dependency and that other legal papers present undue hardship on the Member or living natural parent(s).

(9) **Full-time Student.** An eligible Dependent child may be included under the Enrolled Member's Coverage while a full-time student in Full-Time Attendance at an Accredited School after age nineteen (19) and until the end of the month in which the child reaches age twenty-six (26), or age twenty-three (23) for TriCare Supplement, provided the child, if employed, is not eligible for a substantially comparable medical benefit plan at the place of employment. Failure to document eligibility and Full-Time Attendance or registration prior to loss of Coverage as an eligible Dependent child or as an eligible student under this Plan shall result in loss of the Dependent's eligibility for Coverage until the next Open Enrollment period or subsequent Qualifying Event.

(a) If a full-time student's attendance is interrupted by a period of disability, the Administrator may, upon receipt of appropriate medical information, extend Coverage as a temporarily Disabled Student for the lesser of twelve (12) consecutive months or the period of temporary disability. Documentation of temporary disability must be received by the Administrator no later than thirty-one (31) calendar days following the date of temporary disability.

(b) The Administrator shall require appropriate documentation to demonstrate Full-Time Attendance or registration and eligibility for a student between the ages of nineteen (19) and twenty-six (26) for re-enrollment after a period of non-Coverage.

(10) **Failure to Document Eligibility for Coverage.** For subsections 111-4-1-.04(7) through 111-4-1-.04(9) immediately above, a failure to fully document eligibility of a Dependent shall result in loss of the Dependent's eligibility for Coverage until such documentation is received by SHBP, the next Open Enrollment period under the SHBP or until the occurrence of a subsequent Qualifying Event.

(11) **Totally Disabled Child.** An Enrolled Member shall be entitled to apply for ~~continuation~~ of Coverage of a natural child, legally adopted child or stepchild after age nineteen (19) if the child is physically or mentally disabled, lives with the Enrolled Member or is institutionalized and depends primarily on the Enrolled Member for support and maintenance.

(a) **Application Period.** The Enrolled Member ~~must~~ may apply for ~~continuation of Coverage during Open Enrollment, as a New Hire, or as the result of a Qualifying Event.~~ Enrolled Members whose Totally Disabled Child was a covered dependent on the Member's Family Plan prior to turning age nineteen (19) must apply for continuation of Coverage and include all supporting documentation no later than thirty-one (31) calendar days following the new hire date or prior to the end of the month in which the child reaches age nineteen (19) or loss of loses continuous Coverage as a full-time student under this Plan. If the Enrolled Member fails to complete the request within the allotted time, eligibility for Coverage is limited to the conditions outlined for full-time students or Extended Beneficiaries. If, however, the Dependent child was eligible for Coverage under the SHBP as a disabled Dependent upon reaching age nineteen (19), an Enrolled Member shall be entitled to apply to enroll the disabled Dependent upon loss of other group plan Coverage, provided the Administrator receives the complete

application no later than thirty-one (31) calendar days following the loss of another group health plan Coverage or prior to the loss of continuous Coverage as a full-time student under this Plan.

(b) **Documentation and Approval.** The Administrator shall require documentation as necessary to provide certification that the child is physically or mentally incapable of sustaining, self-supporting employment because of the physical or mental disability and that the child lives at the Enrolled Member's home, unless institutionalized. The documentation may include but is not limited to certification from a qualified medical practitioner that outlines the physical and psychological history, diagnosis, and provides an estimate of length of time for disability, and an estimate of the child's earning capacity. If the documentation is satisfactory to substantiate the physical or mental disability as required in these regulations, the Administrator may approve the continuation for the period of incapacitation. The Administrator may require periodic recertification of the disabling condition and circumstances, provided the recertification is not more frequent than each twelve (12) calendar months or at the end of the projected disability period if that date is less than twelve (12) calendar months.

(12) **Surviving Beneficiary.** An Enrolled Member's Surviving Spouse and eligible Dependent children, who were included in the Coverage by the Enrolled Member may continue Coverage provided an application for continuing Coverage is received by the Administrator within thirty-one (31) calendar days following Coverage termination as a result of the death of the Enrolled Member and one or more of the following conditions are met:

(a) The Surviving Spouse of an Active Employee may continue Coverage provided the Spouse is eligible to immediately receive a monthly benefit payment from a state supported retirement system in an amount sufficient to pay the Premium. The Spouse ~~must~~ may elect Coverage ~~as a Surviving Spouse~~ or as an Employee as a result of the Spouse's own employment, ~~and but~~ cannot elect double or dual Coverage under separate provisions of the SHBP. The Surviving Spouse may elect to continue Coverage for surviving eligible Dependent children. Eligibility of Dependent children shall terminate in accordance with provisions for Dependent children of these regulations. An election to take a lump sum distribution rather than the monthly Annuity negates eligibility to continue Coverage as a Surviving Spouse. Surviving Spouses of Active Employees are also eligible for Coverage under the Extended Beneficiary provisions of Section 111-4-1-.08 of these regulations.

(b) The Surviving Spouse of an Annuitant may continue Coverage provided the Spouse is eligible to immediately receive a monthly benefit payment from a state supported retirement system in amount sufficient to pay the Premium. The Spouse ~~must~~ may elect Coverage ~~as a Surviving Spouse~~ or as an Employee as a result of the Spouse's own employment, ~~and but~~ cannot elect double or dual Coverage under separate provisions of the SHBP. The Surviving Spouse may elect to continue Coverage for surviving eligible Dependent children. Eligibility to continue Dependent children shall terminate in accordance with provisions for Dependent children.

(c) Upon the death of an Active Employee, an eligible Dependent child who is the principal Beneficiary under one of the state supported retirement systems may continue Coverage, provided the Dependent child is not covered as a Dependent child under another contract under the SHBP, and provided the monthly benefit payment from a state supported retirement system is in an amount sufficient to pay the Premium. Eligibility to continue Coverage shall terminate in accordance with Dependent child regulations unless continued as an Extended Beneficiary. Surviving Covered Dependents of Active Employees are also eligible for Coverage under Extended Beneficiary provisions in Section 111-4-1-.08 of these regulations.

(d) Upon the death of a Retired Employee, an eligible Dependent child who is the principal beneficiary under one of the state supported retirement systems may continue coverage, provided the dependent child is not covered as a dependent child under another contract under the SHBP, and provided the monthly benefit payment from a state supported retirement system is in an amount sufficient to pay the premium. Eligibility to continue coverage shall terminate in accordance with provisions for Dependent children.

(e) The Surviving Spouse of Retired Employee who is included in Coverage at the time of death of the enrolled Retiree and who will not receive a monthly annuity payment from one of the state supported retirement systems shall be eligible to enroll oneself and any of the Retiree's Dependent children at the time of the Retiree's death under the following conditions:

1. The Surviving Spouse must make written application no later than thirty-one (31) calendar days following Coverage termination as a result of the death of the Retired Employee; and
2. The parties must have been married at least one full year prior to the death of the Retired Employee; and
3. The Surviving Spouse agrees to pay the monthly premium payment established by the Board in accordance with the established requirements; and
4. Coverage under this provision shall terminate for the Surviving Spouse and any enrolled Dependent children in the event the Surviving Spouse remarries.

(f) The eligible Covered Dependents of an Active State Employee who is killed or receives injury that results in death while acting in the scope of his or her employment may continue Coverage provided the deceased Enrolled Member's Coverage was continuous during the period between injury and death. The eligible Covered Dependents may elect Coverage as a surviving Dependent or as an Employee as a result of the person's own employment, but cannot elect double or dual Coverage under separate provisions of the SHBP. A surviving Covered Dependents must agree to pay the monthly Premium payment established by the Board in accordance with the established requirements. The Surviving Spouse may elect to continue Coverage for eligible Dependent children. Eligibility of Dependent children shall terminate in accordance with provisions for Dependent children.

(g) The Surviving Spouse shall be required to list all eligible Dependents with the Administrator at the time of such election to continue Coverage and shall not be allowed to add another Spouse or other Dependent children acquired in future marriage(s).

(13) Dependent Eligibility Unverified. The Administrator shall define the supporting documentation requirements for verifying Dependent eligibility. Coverage for Dependents whose eligibility is unverified will pend awaiting receipt and review of the documentation. ~~Dependent documentation must be received by the Administrator within thirty one (31) calendar days of the later of the date of request or the Qualifying Event that allows inclusion of the Dependent in Coverage.~~ When the Administrator has verified eligibility of the Dependent, the Coverage will be activated in accordance with the provisions of this Section. If the Administrator cannot verify Dependent eligibility within the allotted time, the Dependent will be ineligible for Coverage. The next opportunity to enroll the Dependent and verify the Dependent's eligibility will be the annual Open Enrollment period or subsequent Qualifying Event. Changes to a different coverage tier will not be allowed based on unverified dependent eligibility.

(14) **Retired Employees Having Intermittent Periods of Active Employment.** Retired Employees who are eligible to continue Coverage under these regulations may elect to return to or continue Active employment with any of the Employing Entities. In such case, the retirement benefit may be suspended or continued; however, the federal Social Security Act requires the health benefit Coverage must be purchased as an Active Employee whenever the eligibility requirements of Section 111-4-1-.04 of these regulations are met. At the point the Employee discontinues Active employment, continuous health benefit Coverage shall be reinstated with the state supported retirement system which previously collected the Premium. In no case, however is an individual who retired prior to the initial legislated funding for that Group of Employees to be entitled to enroll as a Retiree, unless the final Active service period qualifies the Employee for a retirement benefit by one of the state supported retirement systems.

(15) **Judicial Reinstatement of State Employees.** State Employees who are reinstated to employment by the State Personnel Board or the judiciary shall have Coverage reinstated for themselves and any eligible Dependents. If employment reinstatement occurs within twelve (12) calendar months of discharge and back-pay for continuous employment is awarded, all retroactive Premiums must be collected and remitted to the Plan before and Claims incurred during the period may be filed for reimbursement. If back-pay to provide for continuous employment is not awarded, Coverage may be reinstated with the Employee's return to work. If reinstatement occurs following a period longer than twelve (12) calendar months after the discharge, Coverage for the Employee and previously Covered Dependents will be reinstated when the Employee returns to work or in accordance with the judicial review. In any case where the reinstatement overlaps an Open Enrollment period, the Employee will be given fifteen (15) calendar days after reinstatement to modify Coverage in compliance with Open Enrollment guidelines. Pre-existing condition limitations will be waived for the reinstated Employee and all previously enrolled Dependents. Employing Entities shall be responsible for collecting and remitting any Premiums due for the selected Coverage.

(16) **Contract Employees.** Employees who are on approved leave of absence and/or have not terminated their employment may participate in the Plan if their Employer has contracted with the Board to provide inclusion in the SHBP. The Employee will be eligible to participate in accordance with the provisions of the contract.

Authority O.C.G.A. §§ 20-2-55, 20-2-880, 20-2-881, 20-2-885 to 20-2-887, 20-2-895, 20-2-910 to 20-2-912, 20-2-915, 20-2-916, 20-2-923, 31-3-2.1, 45-18-1 et seq., 45-20-2, 47-2-313, 47-6-41, Family and Medical Leave Act of 1993 (FMLA), Social Security Act, Uniformed Services Employment & Reemployment Act-, Americans With Disabilities Act (ADA).

**Rule 111-4-1-.10
Plan Benefits**

Rule 111-4-1-.10(1)(a)(12)

SYNOPSIS

The purpose of the rule change is to eliminate paragraph (1)(a)(12).

EXPLANATION OF CHANGES

Rule 111-4-1-.10(1)(a)(12) regarding the Indemnity Option shall be eliminated as an available Option under SHBP as part of the SHBP strategic plan previously presented to the Board in November 2007.

Rule 111-4-1-.10(4)(e)

SYNOPSIS

The purpose of the rule change is to eliminate paragraph (4)(e).

EXPLANATION OF CHANGES

Rule 111-4-1-.10(4)(e) was originally adopted when Medicare Part B premiums were set at a fixed premium amount per federal rules. Medicare Part B premiums are now means-based, meaning the amount of premium paid by a recipient is based on their "means" or income and will vary based on the recipient. Because of this variation, it is not a valid method for SHBP to use to calculate premium.

Rule 111-4-1-.10(10)

SYNOPSIS

The purpose of the rule change is to reflect changes to State law regarding the Consumer Choice Option.

EXPLANATION OF CHANGES

Rule 111-4-1-.10(10) is added to give the Commissioner the authority to eliminate the Consumer Choice Option in keeping with changes to State law no longer requiring SHBP to offer this Option.

111-4-1-.10 Plan Benefits.

(1) **Creation of Benefit Schedule.** The Board is authorized to establish benefit schedules for Options to be included in a health benefit plan for eligible persons as defined in Georgia law. Benefit schedules for HMO Options may include a different schedule for Medicare enrolled Retirees and non-Medicare enrolled Retirees. The regular insurance Options shall be established upon approval of benefit schedule(s). The dates of approval, modification, addition or deletion of the schedules of the Regular Insurance Options shall be recorded in these regulations.

(a) **Benefit Schedule Approvals.** The benefit schedule for a comprehensive, self-insured, Regular Insurance Standard Option under the State Health Benefit Plan was approved on September 15, 1982 to become effective on January 1, 1983. Amendments to the benefit schedules are recorded on:

1. **December 18, 1996.** Approval was given to adopt the portability requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA); to adopt the requirements of the Newborns' and Mother's Health Protection Act of 1996; and to implement the NurseCall 24 program for an effective date of July 1, 1997;

2. **September 25, 1997.** Approval was given to modify the utilization review program to require participating hospitals to pre-certify of inpatient stays for an effective date of January 1, 1998;

3. **April 23, 1998.** Approval was given to implement a change in the Plan Year from calendar to the State's Fiscal Year; and to adopt the Women's Health and Cancer Rights Act of 1998 for an effective date of July 1, 1999;

4. **July 22, 1999.** Approval was given to implement a Disease State Management pilot program for an effective date of January 1, 2000;

5. **November 10, 1999.** Approval was given to add the hospital DRG pricing contractual provision for an effective date of July 1, 2000;

6. **February 9, 2000.** Approval was given to increase the Maximum Lifetime Benefit to \$2 million; adopt the Standard Preferred Provider Organization (Standard PPO) Option in lieu of the Standard Indemnity Option; and to implement the Consumer Choice Options (CCO) for all managed care plans for an effective date of July 1, 2000;

7. **September 13, 2000.** Approval was given to amend the pharmacy benefit to include a card program with three-Tier co-payments; to enhance Wellness/Preventive Services benefits for High Option, Standard PPO and PPO Choice Options; and to add a national network to the PPO provider network for an effective date of July 1, 2001;

8. **December 12, 2001.** Approval was given for the regular insurance, High Option, to be known as the Indemnity Option for an effective date of July 1, 2002;

9. **January 9, 2002.** Approval was given to amend coverage for cancer clinical trials that meet guidelines established by the Georgia Cancer Coalition for an effective date of June 1, 2002;

10. **January 17, 2003.** Approval was given to amend coverage for specific osseous surgeries for the treatment of periodontal disease for an effective date of July 1, 2003;

11. **March 10, 2004.** Approval was given for the following:

(i) The Administrator shall interpret the general schedules into specific benefit language for inclusion in the Summary Plan Description and for use by the TPA in adjudicating claim payments,

(ii) The Administrator shall authorize the use of established procedures by the TPA to terminate benefit payments if continuation of treatment in the mode being billed is not medically necessary. The Member shall have the right to ask for a record review by medical consultants.

12. The Indemnity Option shall ~~only be available~~ eliminated as an available Option under SHBP to an Enrolled Member and his or her Covered Dependents who maintained such coverage during the Plan Year ending December 31, 2007. ~~Change in coverage resulting from a Qualifying Event shall not be restricted for these Enrolled Members. However, in the event that an Enrolled Member elects another Option, the Enrolled Member shall not be allowed to select the Indemnity Option during any subsequent Open Enrollment periods or during any other allowable enrollment period resulting from a Qualifying Event.~~

(b) The Administrator shall interpret the general schedules into specific benefit language for inclusion in the Summary Plan Description and for use by the TPA in adjudicating claim payments.

(c) The Administrator shall incorporate specific benefit language to be used by the TPA for review of utilization patterns and to implement claim cost containment features, including but not limited to, medical review of excessive utilization and audits of hospital or other claims.

(d) The Administrator shall be authorized to require pre-authorization by the TPA of any new medical service before approval for benefit payment. Generally, the service will not be considered for coverage unless medical consultants/advisors substantiate through literature research that clinical trials demonstrate the medical effectiveness of the service. Other guidelines, such as those of the Federal Drug Administration of the Centers for Medicare & Medicaid Services may also be used, at the discretion of the Administrator, in the determination of coverage.

(e) The Administrator shall authorize the use of established procedures by the TPA for obtaining additional medical information from members and from providers of medical services and supplies, in order to determine the amount and appropriateness of benefit payments.

(f) The Administrator shall establish procedures for permitting the Member to appeal an adverse determination of eligibility for Coverage or of a benefit, service, or Claim. These procedures shall be outlined in the Summary Plan Description to advise the Member of the process to initiate an appeal. However, the Administrator has delegated the final authority to the TPA for approval in accordance with the schedule of Benefits and the interpretation thereof. The Administrator shall have final authority for approval of all eligibility appeals.

(g) The Administrator may contract for or employ professionals from any medical discipline to advise the Administrator on continuing medical necessity, quality of medical care, or the level of fees charged by the providers of medical care.

(h) The Administrator is authorized to develop appropriate medical policy in conformity with the schedule of benefits and these regulations so that new procedures will be included for coverage when the new procedures are adopted as accepted medical practice and that medical procedures which are excessively used without significantly improving the treatment of an illness or injury are reviewed.

(2) **Pre-existing Conditions.** Benefits will be limited to one thousand dollars (\$1,000.00) for the treatment of a Pre-existing Condition until the person has been covered under the Plan for twelve (12) consecutive months.

(a) The twelve (12) calendar month pre-existing condition waiting period will be reduced by the length of time that Creditable Coverage existed under the following conditions:

1. The Creditable Coverage must not have time periods of non-coverage that lasted for more than sixty-three (63) calendar days;

2. The Member provides certification of the Creditable Coverage and the time beginning and ending time periods;

3. The Creditable Coverage ending period occurred within sixty-three (63) calendar days of the Member's employment date or waiting period for SHBP Coverage when Coverage begins at a time other than upon employment;

4. When the most recent Creditable Coverage terminated less than sixty-three (63) calendar days prior to the waiting period for SHBP Coverage, the pre-existing period shall be reduced by the same period(s) of prior Creditable Coverage (periods without a break of coverage of more than sixty-three (63) calendar days, but not for the SHBP waiting period (i.e., first full month before the effective date); and

(b) If the Member or dependent provides satisfactory documentation to the Administrator that the covered person has been free of treatment for the Pre-existing Condition for six (6) consecutive months, the limitation will be waived upon approval by the Administrator. If the Administrator requests additional documentation regarding the Pre-existing Condition, the Member or Dependent will not receive benefits until satisfactory documentation has been presented for the Administrator's approval.

(c) A new Pre-existing Condition requirement will not be applicable if an individual's SHBP coverage is interrupted for any reason by an unpaid Coverage period equal to or less than four (4) calendar months. A new Pre-existing Condition requirement will not be applicable when Coverage for all Members of the family are transferred from one Spouse to the other Spouse or an enrolled Dependent becomes covered as an Employee.

(d) A Pre-existing Condition limitation will not be applied to newborns covered within thirty-one (31) calendar days of birth or to adoptees, under the age of 18, covered within thirty-one (31) calendar days of adoption.

(3) **Coordination of Benefits.** Coordination of Benefits provisions are intended to establish uniformity in the permissive use of other insurance provisions among health insurance carriers and self-insured group plans. Coordination of benefits within the Plan shall conform generally to the Uniform Guidelines as adopted by the National Association of Insurance Commissioners.

(a) "Group Policy or Group Type Contract" means that the policy or contract is not available to the general public and can be obtained and maintained only because of the covered person's Membership in or connection with a particular organization or group. Franchise policies, even though provided on a group basis, are considered individual rather than group policies. Group policies or contracts usually, but not exclusively, mean that the Employee's cost of the policy or contract is employer sponsored with the cost paid by the employer or deducted from the Employee's compensation.

(b) When it is determined that this Plan is not the primary plan, the plan which pays benefits first, benefits are limited to the difference between the benefits paid by the primary plan and total eligible charges under this Plan, but no more than this Plan would have paid had the Plan been the primary plan for those eligible charges.

(c) Primary payor determination shall be in accordance with the following guidelines.

1. If another plan is involved and does not contain a provision for coordinating its benefits, that plan will be the primary plan; or

2. If there is federal or Georgia law requiring another plan to be the secondary plan, this Plan will be the primary plan; or

3. In other cases, the order of primary plan determination shall be:

(i) When the patient is covered as an Employee; or

(ii) When the patient is covered as the eligible and unmarried Dependent child of the parent whose birthday occurs first in the calendar year; or

(iii) When the patient is covered as the eligible and unmarried Dependent child of a divorced or legally separated Employee who has custody of that child, unless:

(I) the divorce or legal separation decree assigns financial responsibility for the child's health care expenses to the other divorced or legally separated parent, or

(II) the other divorced or legally separated parent's group health care plan establishes itself as the primary plan.

(iv) When the patient is covered as the eligible and unmarried dependent of a divorced or legally separated parents who have joint (50% - 50%) custody, determination is as if the parents were not divorced or separated.

4. When the active Member was covered under another group plan prior to the effective date of coverage in this Health Benefit Plan, that plan will be primary. A change in the amount or scope of benefits provided by a plan, a change in the carrier insuring the plan or a change from one type of plan to another does not constitute a new plan for the purposes of this guideline.

5. When the Member or eligible Dependents are covered by another plan as an Employee and under this Health Benefit Plan as a Retired Employee or Extended Beneficiary, or Dependent of the Retired Employee or Surviving Spouse of an Employee, the other plan will be primary.

(d) When payment has been made by this Plan in excess of the maximum amount of payment necessary at that time to satisfy the intent of the Coordination of Benefit provision, the Plan shall have the right to recover the excess payments, payments greater than one hundred percent (100%) of eligible and covered charges, from among the other insurers, the Member or the person (entity) to whom payment was made.

(4) Medicare Coordination of Benefits and Medicare Subrogation. By federal law, Medicare is primary for persons who are retired or who are disabled, subject to the Medicare Secondary provisions. By federal law, effective May 1, 1986, Medicare is secondary for active Employees and their eligible spouses who are age sixty-five (65) or older. The Administrator is authorized to modify the procedures if future federal law requires such change.

(a) Prior to the Member reaching age sixty-five (65), the Administrator shall notify the Member that an election for determining the primary payor must be made. The Administrator shall also inform the Employee that electing Medicare as primary will eliminate his eligibility to continue coverage under the SHBP.

(b) For those Members who are active and elect the SHBP as the primary payor, notification will be transmitted to the TPA and other vendors to facilitate processing future claims as the primary payor. The Administrator shall assume that the Spouse, who is age sixty-five (65) or older, of a Member who continues to work has chosen the SHBP as the primary payor, unless the Member or his Spouse otherwise notifies the Administrator.

(c) When retired Members or their eligible Dependents are enrolled in Medicare, the Regular Option's liability will be limited to the secondary reimbursement amount. When it is determined that this Plan is secondary to Medicare, benefits are coordinated according to the Plan Options elected. When a provider has accepted the Medicare assignment, any charges greater than the Medicare approved amount shall not be considered eligible charges under this Plan.

(d) When it is determined that a Member is covered under the SHBP as the Member and as a Dependent, the payment order shall be as follows:

1. If one Spouse is working and one Spouse is non-working and is age sixty-five (65) or older, the SHBP is primary under the working Spouse's coverage, Medicare is secondary, and the Plan is tertiary payor under the non-working Spouse's coverage.

2. If both Spouses are non-working, Medicare is primary payor, the coverage of the patient Spouse is secondary, and the coverage of the Dependent Spouse is tertiary payor.

~~(e) When HMO enrolled Retirees or their eligible dependents are entitled to Medicare and fail to enroll in Parts A, B and D of Medicare, the Member's premium shall be increased by two (2) times the Medicare Part B premium for each non-Medicare enrolled person. The Commissioner is authorized to determine an equitable premium for HMO Members who were not informed of the increased premium when the Member was first eligible for Medicare enrollment or for Members who are not eligible for Parts A, B and D Medicare coverage.~~

(5) **Exclusions.** Exclude expenses incurred by or on account of an individual prior to the effective date of coverage; expenses for services received for injury or sickness due to war or any act of war, whether declared or undeclared, which war or act of war shall have occurred after the effective date of this plan; expenses for which the individual is not required to make payment; expenses to the extent of benefits provided under any employer group plan other than this plan of benefits in which the state participates in the cost thereof. In addition, the Administrator shall publish in the Summary Plan Description interpretative language showing the exclusions for the following types of charges:

(a) Charges for treatment for Pre-existing Conditions in excess of one thousand dollars (\$1,000);

(b) Charges for treatment or supplies which are determined to be not medically necessary;

(c) Charges for treatment before the effective date of coverage or after coverage termination, except for Extended Coverage benefits;

(d) Charges other than Wellness/Preventive benefits, that are not specifically related to the care and treatment of a sickness or an injury;

(e) Charges for treatment specifically for dental or vision care;

(f) Charges for treatment for experimental or investigative services or supplies;

(g) Charges that are considered educational or treatment to restore learning capacity;

(h) Charges in connection with custodial care, extended care facilities or a nursing home;

(i) Charges in connection with rehabilitation, rehabilitation therapy, or restorative therapy when the condition is no longer expected to improve significantly in a reasonable and generally predictable period of time;

(j) Charges in connection with therapy for learning disabilities;

(k) Charges for prosthesis or equipment which are determined to be not medically necessary.

(6) **Actions.** In creating the SHBP, neither the Georgia General Assembly nor the Board of Community Health has waived its sovereign immunity. Thus no action either in law or in equity, can be brought or maintained against the State of Georgia, the Board of Community Health, or any other department or political subdivision of the State of Georgia to recover any money under this Plan. In like fashion, no suit may be maintained against any officials or Employees of these bodies if the ultimate financial responsibility would have to be borne by public Funds from the General Treasury, the health benefit Funds or elsewhere.

(a) The Board of Community Health, however, does reserve the right to maintain any suits, either in its own name, or through its officials, Employees, or agents, which it deems necessary to the administration of the SHBP, including actions to recover money from participants, beneficiaries, agents, Employees, officials, or any other person.

(b) The Board of Community Health reserves the right to modify its Benefits, Coverages, and eligibility requirements at any time, subject only to reasonable advance notice to its Members. When such a change is made, it will apply as of the effective date of the modification to any and all charges which are incurred by Members from that date forward, unless otherwise specified by the Board of Community Health.

(c) The Administrator is authorized to act as interpreter of the terms and conditions of the Plan.

(7) **Non-duplication of Benefits and Subrogation.** The Plan will not duplicate payments for medical expenses made under third-party personal-injury-protection contracts nor will it duplicate payments made as the result of any litigation. The Plan will be subrogated to any right of recovery that a Member has against a person or organization where medical expenses were incurred as a result of injuries suffered because of alleged negligence or misconduct. In any case where the primary plan provides for subrogation for third-party liability and this Plan would be determined to be secondary, benefits under this Plan shall be reduced to the amount that would have been paid under the secondary provisions of this Plan.

(8) **Extended Disability Benefits.** If coverage terminates under this Plan at a time when the Member or eligible Dependent is totally disabled, reimbursement for that individual's treatments

for the condition that caused the disability shall continue for up to four (4) additional calendar months after coverage termination.

(a) The Administrator shall require satisfactory documentation from the physician for approval of the Extended Coverages. At minimum the documentation from the physician shall include a statement of the diagnosing disability and of the duration of the condition.

(b) Eligibility for Extended Coverages under any of the provisions in these regulations or conversion to a private pay policy is predicated on the application being filed in accordance with the specified time from coverage termination rather than the extended benefit period.

(9) **Recovery of Benefit Overpayments.** The Administrator shall seek repayment for any benefits paid to any individual, corporation, firm, or other entity who or which is not qualified, in the opinion of the Administrator, to receive benefits from the Plan.

(a) The Administrator shall establish procedures for collecting the overpayments, duplicate payments, or wrong payee payments. The procedures may include, but are not limited to, establishing installment payments, withholding future benefit payment, or filing suit or garnishment.

(b) The Administrator shall establish procedures to collect the amounts in excess of the payments allowed in the Coordination of Benefits or Medicare Coordination of Benefits regulations.

(10) Consumer Choice Option. The Commissioner shall have the authority to eliminate the Consumer Choice Option.

Authority O.C.G.A. §§. 20-2-881 to 20-2-885, 20-2-887, 20-2-911 to 20-2-915, 33-20A-9.1, 45-18-1 et seq., Health Insurance Portability and Accountability Act of 1996 (HIPAA), Social Security Act.