

**RULES
OF
DEPARTMENT OF COMMUNITY HEALTH**

**CHAPTER 111-4-1
STATE HEALTH BENEFIT PLAN**

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(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 as an Option 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 conditioned 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.

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

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