

**RULES
OF
DEPARTMENT OF COMMUNITY HEALTH**

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

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111-4-1-.01 Definitions.

(1) **“Accredited School”** for the purpose of determining eligibility under these regulations means any one of the following types of schools:

(a) Any secondary educational or secondary institution with postsecondary programs accredited or pre-accredited by accrediting associations that are recognized by the United States Secretary of Education; or

(b) Any professional, technical, occupational and specialized school accredited or pre-accredited by national specialized accrediting agencies recognized by the United States Secretary of Education; or

(c) Any specialty or other school administered by the Department of Education or Post Secondary Vocational Board of the State of Georgia; or

(d) Any school that has applied for or is a “candidate for” accreditation under Sections 111-4-1-.01 (1)(a) or 111-4-1-.01 (1)(b) of these regulations; or

(e) Any institution of higher education as defined by the Higher Education Act of 1965 (20 USCS 1141).

(2) **“Active”** means that the ~~SHBP Subscriber~~Employee is receiving compensation or is on Approved Leave of Absence ~~Without Pay~~ through a department, school system, Local Employer, agency, authority, board, commission, county department of family and children services, county department of health, community service board, or Contract Employer and for whom the Employee’s cost of Coverage is stated as a payroll Deduction or Reduction.

(3) **“Acts”** or **“The Acts”** or **“The Health Insurance Acts”** ~~or “Law” or “The Law”~~ mean the legislative Acts that establish the Health Insurance Plans for State

Employees, Teachers, and Public School Employees and are designated in the Official Code of Georgia Annotated as Article 1 of Chapter 18 of Title 45 and Articles 880 and 910 of Chapter 2 of Title 20.

(4) **“Administrator”** means the Department of Community Health or the Commissioner of the Department of Community Health.

(5) **“Administrative Services”** means the services that are provided by contract for a self-insured Hhealth Benefit Plan.

~~(6) **“Annuitant”** means a Retired Employee or surviving spouse or dependent child who receives a monthly retirement benefit from the Employees’ Retirement System, Georgia Legislative Retirement System, Superior Court Judges Retirement System, District Attorneys’ Retirement System, Teachers Retirement System, Public School Employees Retirement System, local school system retirement system or Fulton County Retirement System.~~

~~(7)~~(6) **“Approved Leave of Absence Without Pay”** means a period of time approved by the appropriate organizational official during which the Employee is absent from work and is not in pay status.

~~(8)~~(7) **“Beneficiary”** means an Employee, Surviving Sspouse, divorced or legally separated Sspouse, or eligible Dependent child who loses Coverage under these regulations.

~~(9)~~(8) **“Benefits”** mean the schedule of Benefits of health care services eligible for approval of payments under the Options approved by the Board. ~~—approved by the Board of Community Health for determining the payment amounts.~~

~~(10)~~(9) **“Board of Community Health”** or **“Board”** means the governing body authorized to exercise jurisdiction over the SHBP pursuant to O.C.G.A. §§ 31-5A-3 and 31-5A-4.

~~(11)~~(10) **“Cafeteria Plan”** means a plan which meets the requirements of the Regulations of the Internal Revenue Service under Internal Revenue Code (IRC) 125.

~~(12)~~(11) **“Certificated Capacity”** means the Employee holds valid certification; is not assigned to a position that requires certification as a qualification; the Employee’s compensation is determined, at least in part, based upon the certificate; and the Employee is a member of the Teachers Retirement System or other Public School Teacher retirement system.

~~(13)~~(12) **“Certificated Position”** means the Employee holds valid certification; is assigned to a position that requires certification as a qualification; the Employee’s compensation is determined, at least in part, based upon the certificate; and the Employee is a member of the Teachers Retirement System or other Public School Teachers retirement system.

~~(14)~~(13) **“Claim”** means any bill, invoice, or other written statement from a specific provider for health care services or supplies submitted in accordance with the

~~requirements of the SHBP for a specific eligible Member—the approved form(s) for presenting a request for determination of the payment amount due to an Employee, Extended Beneficiary, or assignee.~~

~~(15)~~(14) “**Commissioner**” means the Commissioner of the Department of Community Health as created by O.C.G.A. § 31-5A-6.

~~(16)~~(15) “**Contract Employee**” means a person employed by one of the entities that contracts with the Board of Community Health to provide health benefit Ce coverage under the SHBP, and who is not considered to be an independent contractor.

~~(17)~~(16) “**Contract Employer**” means one of the organizational entities that has elected to contract with the Board of Community Health for inclusion of their Employees in the SHBP.

~~(18)~~(17) “**Contribution**” means the amount or percentage of salaries to be paid by an Employing Entity or State Department of Education for Employees and Retirees for health benefit Ce coverage.

~~(19)~~(18) “**Coverage ~~Tier~~ or ~~Tier~~**” means the type, Tier, and Option of contract offered to a ~~Subscriber~~Enrolled Member.

~~(20)~~(19) “**Covered Dependent**” means any individual eligible under these regulations and for whom the Premium has been paid by the Employee, Retiree, or Extended Beneficiary.

~~(21)~~(20) “**Creditable Coverage**” means health insurance ~~coverage~~ that may serve to reduce a Pre-existing Condition ~~coverage~~ limitation period. Creditable Ce coverage shall include health plan offering~~coverage~~ under the following type plans: group health plans; individual health policies; Hhealth Maintenance Organizations (HMOs); Medicaid; Medicare; or other governmental health programs. Disease specific ~~coverage~~policies (i.e., cancer insurance), disability insurance, and insurance that provides incidental health ~~benefits~~insurance (i.e., auto insurance) is not Creditable Ce coverage.

~~(22)~~(21) “**Deduction**” or “**Reduction**” means the Premium amount to be remitted to the Administrator as the Employee’s or Retiree’s share of the cost of the elected Coverage ~~Tier and Option~~.

~~(23)~~(22) “**Dependent**” means any eligible Sspouse, De dependent child, full-time student, or totally disabled child or other child(ren) if the children live with the ~~subscriber~~Member permanently and are legally dependent on the ~~subscriber~~Member for financial support.

~~(24)~~(23) “**Disabled Student**” means a full-time student who withdraws from all or part of coursework because of an illness or injury provided the student will be registered to return to full-time status during the succeeding quarter or semester (or the Fall quarter if the Summer quarter is the succeeding quarter). The Administrator has the discretion to determine, based on the record, that a child is a full-time student when there is documentation that the registered hours are less than the normal institution’s full-time requirements during periods of full-time status or period of disability.

~~(25)~~(24) **“Employee”** means any eligible, Active State Employee, ~~T~~teacher, or ~~P~~public ~~S~~school Employee.

~~(26)~~(25) **“Employing Entity”** means any department, school system, ~~L~~local ~~E~~employer, agency, authority, board, commission, county department of family and children services, county department of health, community service board or retirement system that employs or issues an annuity check to an Employee or Retiree as defined in these regulations.

(26) **“Enrolled Member”** means the contract holder who may be the Employee, Retiree, Contract Employee, or Extended Beneficiary who is currently enrolled in Coverage and who has paid the necessary Deduction or Premium for such Coverage.

(27) **“Extended Beneficiary”** means the individual who was covered as an Active or Retired Employee, Employee on ~~A~~approved ~~L~~leave of ~~A~~absence ~~W~~without ~~P~~pay or person who was covered as a ~~S~~spouse or eligible ~~D~~dependent of an Active or Retired Employee or Employee on ~~A~~approved ~~L~~leave of ~~A~~absence ~~W~~without ~~P~~pay on the day SHBP ~~C~~coverage was lost as a result of a ~~Q~~qualifying ~~E~~event under the requirements of federal law and regulation known as the Consolidated Omnibus Budget Reconciliation Act (COBRA), as amended.

(28) **“Full-time Attendance”** means that the full-time student is registered for the minimum number of hours required to meet that ~~A~~accredited ~~institution’s~~~~School’s~~ full-time status. A withdrawal from some coursework that reduces the number of hours to less than full-time during the ~~school’s summer break quarter~~ will not affect ~~F~~full-~~T~~ime ~~A~~attendance provided the student will be registered to return to full-time status during the ~~succeeding Fall~~quarter or semester ~~(or the Fall quarter if the Summer quarter is the succeeding quarter)~~. Full-~~T~~ime ~~A~~attendance ends at the end of the month in which coursework is completed or if the student ceases attendance.

(29) **“Fund”** or **“Health Benefit Fund”** or **“Health Insurance Fund”** means the ~~S~~state ~~E~~mployees ~~H~~health ~~I~~nsurance ~~F~~fund, the ~~T~~eachers ~~H~~health ~~I~~nsurance ~~F~~fund, and the ~~P~~ublic ~~S~~chool ~~E~~mployees ~~H~~health ~~I~~nsurance ~~F~~fund.

(30) **“Group”** means all eligible Employees authorized under a specific chapter, article or part of the Official Code of Georgia Annotated for ~~C~~coverage under the SHBP.

(31) **“Health Maintenance Organization”** or **“HMO”** means an organization authorized and certified to provide services under Chapter 21 of Title 33 of the Official Code of Georgia Annotated.

(32) **“Local Employer”** means a county or independent board of education, regional or county libraries, of Georgia, the governing authority of the Georgia Military College, or Regional Educational Service Areas.

(33) **“Managed Care Plan”** means plans that provide health Coverage through a specified network of providers with benefit differentials in cost sharing between in-network and out-of-network providers.

~~(33)~~(34) **“Medicare Advantage Medicare+Choice”** means the managed care Option that is offered to Retirees through an HMO or other legally licensed organization and that is approved through the Centers for Medicare and Medicaid Services (~~“CMS”~~) for Medicare enrolled Retirees.

~~(35)~~ **“Member”** means a benefit eligible or ineligible Employee, former Employee, Retiree, or Extended Beneficiary.

~~(34)~~(36) **“Option”** means the type of benefit schedule or premium rating category that is offered to ~~the Subscriber~~an eligible Member through ~~R~~regular ~~I~~nsurance, ~~or~~ an HMO, ~~supplement, or other health benefit offering of the SHBP.~~

~~(35)~~(37) **“Partial Disability”** means the ~~Subscriber~~Employee is unable to perform the normal, full-time duties of the individual’s occupation or employment due to disability, but is certified by his/her physician to return to work on a part-time basis following a period of disability for a fixed period of time in that individual’s occupation or in a modified work capacity.

~~(36)~~(38) **“Payor, Primary”** means the entity which is required by contract or law to reimburse or pay for ~~covered health services~~~~medical care treatment~~ without regard to any other benefit entitlement or contractual provision.

~~(37)~~(39) **“Payor, Secondary”** means the entity which does not have the primary liability for providing benefit reimbursement for ~~medical care treatment~~ ~~covered health services~~.

~~(38)~~(40) **“Plan”** or **“Health Insurance Plan”** means the insurance Options formed by the combination of ~~H~~health ~~I~~nsurance ~~P~~plans for ~~S~~state Employees, ~~T~~teachers, and ~~P~~ublic ~~S~~chool Employees.

~~(39)~~ **“Plan Options”** are the insurance Options offered to state Employees, teachers, public school Employees and contract Employees and consist of the following: PPO Basic, PPO Premier, PPO Choice Basic, PPO Choice Premier, Indemnity Basic, Indemnity Premier, or an HMO.

~~(40)~~(41) **“Plan Year”** means the twelve-month period beginning on ~~January~~July-1, and ending on the following ~~December 31~~June-30. The Commissioner shall have the flexibility to modify the SHBP Plan Year.

~~(41)~~(42) **“Pre-existing ~~C~~ondition”** means a sickness, injury, or other condition (except for pregnancy) for which medical advice, diagnosis, care or treatment was recommended or received within the six ~~(6)~~ months immediately before ~~C~~overage began under the Plan. Genetic status is not a ~~P~~re-existing ~~C~~ondition unless diagnosis, care or treatment was rendered within the six-month period. (Health Insurance Portability and Accountability Act of 1996).

~~(42)~~(43) **“Premium”** means the ~~Enrolled Member’s~~Subscriber’s cost as set by the Board of Community Health for the ~~elected~~ Coverage ~~Tier and Option~~.

~~(43)~~(44) **“Public School Employee”** means a person who is employed by the local school system, meets the eligibility requirements under these regulations and is receiving a salary for services.

~~(44)~~(45) **“Qualifying Event”** means an event as defined by federal law or regulation that authorizes: (a) eligibility for Extended Coverage or (b) change in coverage election under a health benefit plan. Qualifying ~~E~~events include changes in employment or family status as outlined in Sections 111-4-1-.06, 111-4-1-.07, and 111-4-1-.08 of these regulations.

~~(45)~~(46) **“Rate”** means an amount set by the Board for the ~~Enrolled MemberSubscriber~~ ~~P~~premium or an amount or percentage of salary set by the Board as the ~~E~~employer’s ~~C~~ontribution.

~~(46)~~(47) **“Regular Insurance”** means the self-insured ~~“PPO–Basic”, “PPO Premier”, “PPO Choice Basic”, “PPO Choice Premier”, and “Indemnity Basic” and “Indemnity Premier”~~ Options ~~that are offered on a statewide basis.~~

~~(47)~~(48) **“Retired Employee”** or **“Retiree”** or **“Annuitant”** means a former ~~S~~state Employee, former ~~T~~teacher, or former ~~P~~ublic ~~S~~school Employee who met the eligibility criteria when ~~A~~active or was included by specific legislation and who receives a monthly benefit from the Employees’ Retirement System, Georgia Legislative Retirement System, Teachers Retirement System, Public School Employees Retirement System, Superior Court Judges Retirement System, District Attorneys’ Retirement System, or local school system retirement system and an eligible and former Employee of a county department of family and children services or county department of health who receives a monthly benefit from the Fulton County Retirement System. In the case of a county health department Employee, the Employee must have been covered as an ~~A~~active ~~Enrolled MemberEmployee~~ and continued ~~C~~overage upon receiving an annuity from the Fulton County Retirement System. Retiree shall also include ~~Enrolled MembersSubscribers~~ who remit payment directly to the SHBP and who are eligible for ~~C~~overage as a ~~S~~surviving ~~S~~spouse of the eligible Employee or Retiree, and Extended Beneficiary who is eligible by virtue of State ~~L~~aw, or an ~~A~~annuitant whose monthly benefit from a retirement system is insufficient to pay the ~~P~~premium for the ~~CoverageOption~~ in which enrolled.

~~(48)~~(49) **“Retiring Employee”** means a ~~covered Enrolled MemberSubscriber~~ who is eligible to receive an immediate retirement benefit payment from the Employees’ Retirement System, Georgia Legislative Retirement System, Teachers Retirement System, Public School Employees Retirement System, Superior Court Judges Retirement System, District Attorneys’ Retirement System or local school system retirement system or an ~~Enrolled Membereligible Employee~~ of a county department of family and children services or county department of health who is eligible to receive an immediate retirement benefit payment from the Fulton County Retirement System.

~~(49) “Service Area” means the geographic area in which a healthcare provider network contracts to provide medical care.~~

(50) **“Spouse”** means an individual who is not legally separated, who is of the opposite sex to the ~~Enrolled Member~~Subscriber and who is legally married or who submits satisfactory evidence to the Administrator of common law marriage to the Employee or Retired Employee entered into prior to January 1, 1997 and is not legally separated.

(51) **“State Employee”** means a person employed by the State or a community service board and who meets the eligibility definitions of these regulations and who is receiving a salary or wage for services rendered.

(52) **“State Health Benefit Plan”** or **“SHBP”** means the health benefit plan administered by the Department of Community Health covering State Employees, Public School Teachers, Public School Employees, Retirees and their eligible Dependents, and other entities under The Acts for health insurance combination of all Options offered to all Subscribers under the acts for health insurance that are operated under the jurisdiction of the Board of Community Health.

~~(53) “Subscriber” means the contract holder who may be the Employee, Retiree, contract Employee or extended beneficiary and who is eligible for coverage and who has paid the necessary deduction or premium for such coverage.~~

~~(54)~~(53) **“Summary Plan Description”** is a booklet that describes the health benefits and other provisions of the State Health Benefit Plan (SHBP) specific to the Coverage elected by the Enrolled Member.

~~(55)~~(54) **“Surviving Spouse”** means the living Spouse of a deceased Enrolled Member~~Employee or Retiree.~~

~~(56)~~(55) **“Teacher”** or **“Public School Teacher”** means a person employed by a local school system in a Certificated Position and who meets the eligibility definitions of these regulations and who is receiving a salary or wage for services rendered.

~~(56) “Tier” means the number and relationship to the Enrolled Member of the persons enrolled under the Member’s Coverage.~~

~~(57)~~(57) **“Total Disability”** means that the Enrolled Member~~Subscriber~~ is not able to perform any and every duty of the individual’s occupation or employment or that the Dependent is not able to perform the normal activities of a person of like age or sex.

~~(58)~~(58) **“TPA”** or **“Third-party Administrator”** means an approved contractor for adjudicating ~~C~~laims, paying Claims, and performing other administrative processes.

Authority O.C.G.A. Secs. 20-2-881, 20-2-892, 20-2-911, 45-18-2, Health Insurance Portability and Accountability Act of 1996 (HIPAA), Consolidated Omnibus Budget Reconciliation Act (COBRA).
History. Original Rule entitled “Definitions” adopted. F. Apr. 18, 2005; eff. May 8, 2005.

PROPOSED RULE
OF THE
GEORGIA DEPARTMENT OF COMMUNITY HEALTH
RULE 111-4-1-.01

STATEMENT OF PURPOSE AND MAIN FEATURES OF PROPOSED RULE:

The purpose of this proposed rule is to make the rules and regulations consistent with anticipated business operation changes.

DIFFERENCES BETWEEN EXISTING RULE AND PROPOSED RULE:

Grammatical errors or errors in capitalization have been made.

Items have been renumbered appropriately.

The words “of these regulations” have been added to the end of 111-4-1-.01(1)(d) for clarification purposes.

The defined term “Employee” replaces the words “SHBP Subscriber” in 111-4-1-.01(2) inasmuch as the term “Subscriber” is being deleted from these regulations.

In 111-4-1-.01(3), “Law” or “The Law” have been deleted as defined terms inasmuch as “Acts,” “The Acts,” or the “Health Insurance Acts” cover the intended meaning sufficiently and “law” may be used throughout the regulations to reference a variety of laws.

The independent definition for “Annuitant” has been deleted from the regulations and the word Annuitant has been combined with the definition for “Retired Employee” or “Retiree” at 111-4-1-.01(48) as the terms all share the same meaning.

Wording has been added to the definition of “Benefit” in the newly renumbered 111-4-1-.01(8) for clarity but the meaning remains unchanged.

The wording for the definition of the term “Claim” has been revised in the newly renumbered 111-4-1-.01(13) but the meaning of the defined term remains the same.

In 111-4-1-.01(18), the interchangeable terms “Coverage Tier” and “Tier” are being replaced by the single term “Coverage,” as Coverage is a newly defined term that is appropriate in the immediate context. The words “Tier and Option” are being inserted as a descriptor of a type of Coverage contract, and the word “Enrolled Member” (as used

specifically in this subsection) replaces the term “Subscriber,” as Enrolled Member is being used as the defined term for the contract holder.

In 111-1-4-.01(21), the word “Premium” has been inserted before the word “amount” to clarify that the amount deducted will be a Premium share and the words “Tier and Option” have been deleted inasmuch as Tier and Option are no longer necessary or applicable as used in the immediate context.

The newly defined term “Member” replace the old term “Subscriber” as an indicator of contract holder in the newly renumbered 111-1-4-.01(22).

“Enrolled Member” is inserted as a new defined term at 111-4-1-.01(26) used for making specific reference to contract holders who have remitted monthly Deductions or Premiums.

In 111-4-1-.01(28), the word “School” replaces the word institution so that the defined term “Accredited School” replaces the words “Accredited institution.” The words “school’s summer break” replace the word “quarter” so that it is clear that the summer period, which entails non-attendance for many students, will not result in Coverage termination. Finally, in the next to last sentence, the word “succeeding” has been deleted and the word “Fall” inserted before the word quarter, while the parenthetical “(or the Fall quarter if the Summer quarter is the succeeding quarter)” has been deleted in order to eliminate unnecessary words and phrasing for a clearer read.

“Managed Care Plan” has been inserted as a new definition at 111-4-1-.01(33) inasmuch it will be used as a defined term in these regulations.

The words “Medicare Advantage” replace the words “Medicare Choice” as a defined term as “Medicare Advantage” is the new name for “Medicare Choice,” and the acronym “CMS” is included in parenthetical immediately following the words Centers for Medicare Medicaid Services in the newly renumbered 111-4-1-.01(34).

The defined term “Member” is inserted at 111-4-1-.01(35) as the newly defined term for Employees, Retirees, or Extended Beneficiaries of the SHBP.

In the newly renumbered 111-4-1-.01(36), the newly defined term Member replaces the alleviated term “Subscriber” (deleting the word “the” that appears in front of “Subscriber” and placing the words “an eligible” in front of the word “Member” to emphasize the requirement of eligibility), and the words “supplement or other health benefit offering of the SHBP” have been added to clarify that use of the term “Option” may include any supplement(s) or other health benefit offering of the SHBP.

The word “Employee” replaces the word “Subscriber” in the newly renumbered 111-4-1-.01(37) inasmuch as the word Subscriber will no longer be a defined term.

The words “covered health services” replace the words “medical care treatment” in the newly renumbered 111-4-1-.01(38) inasmuch as the new words convey the intended meaning more clearly.

The words “covered health services” replace the words “medical care treatment” in the newly renumbered 111-4-1-.01(39) inasmuch as the new words convey the intended meaning more clearly.

The term “Plan Options” has been deleted at the former 111-4-1-.01(39) inasmuch as the definition is redundant and is, therefore, unnecessary.

Wording is added to 111-4-1-.01(41) changing the Plan Year from July 1 to June 30 to January 1 to December 31, consistent with the Plan’s current operations, and stating that the Commissioner may elect to modify the SHBP Plan Year.

The number 6 is placed in a parenthetical behind the word six in 111-4-1-.01(42).

In 111-4-1-.01(43), the newly defined term “Enrolled Member” replaces the alleviated term “Subscriber,” the word “elected” is placed in front of the word “Coverage” for clarity, and the words “Tier and Option” have been deleted inasmuch as Tier and Option are no longer necessary for use in the immediate context.

The newly defined term “Enrolled Member” replaces the eliminated term “Subscriber” in 111-4-1-.01(46) as appropriate in the immediate context.

Any Options that have been eliminated under the SHBP have been stricken from the definition of “Regular Insurance” in 111-4-1-.01(47).

In 111-4-1-.01(48), the word “Annuitant” has been added as an interchangeable defined term with “Retired Employee” or “Retiree” inasmuch as “Annuitant” shares the same meaning as “Retired Employee” or “Retiree.” The newly defined term “Enrolled Member” replaces both “Employee” and “Subscriber” in 111-4-1-.01(48) and the newly defined term “Coverage” replaces “Option” all as appropriate in the specific context.

In 111-4-1-.01(49), the word “covered” before the word “Subscriber” as it is no longer necessary to convey the intent of the sentence. Also, the newly defined term “Enrolled Member” replaces “Subscriber” and “Employee” as appropriate in the specific contexts.

The defined term “Service Area” at the former 111-4-1-.01(49) has been deleted inasmuch as the definition is no longer essential for these regulations.

The newly defined term “Enrolled Member” replaces the alleviated term “Subscriber” in 111-4-1-.01(50) as appropriate for the specific context.

The wording of the definition for “State Health Benefit Plan” or “SHBP” in 111-4-1-.01(52) has been revised, but the meaning of the defined term remains the same.

The term “Subscriber” has been deleted at the former 111-4-1-.01(53) as the word “Subscriber” will no longer indicate a contract holder of the SHBP.

The words “health benefits and other” have been inserted in front of the word “provisions” in the newly renumbered 111-4-1-.01(53) in order to clarify what type of provisions are addressed in the SHBP’s Summary Plan Description. Also, language has been added to clarify that the Summary Plan Descriptions will be specific to the Coverage elected by the Enrolled Member.

The newly defined term “Enrolled Member” replaces the words “Employee or Retiree” at the newly renumbered 111-4-1-.01(54) in that the new term encompasses enrolled Employees and Retirees.

A new definition has been added for “Tier” at 111-4-1-.01(56) as an indicator of the number and relationships of persons to Enrolled Members under the Member’s Coverage.

The newly defined term “Enrolled Member” replaces the alleviated term “Subscriber” at 111-4-1-.01(57) as appropriate in the immediate context.

The Consolidated Omnibus Budget Reconciliation Act (COBRA) has been added as a cited authority at the end of 111-4-1-1-.01.

111-4-1-.02 Organization.

(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 Hhealth Insurance Plan for group ~~hospitalization and surgical and~~ medical insurance against the financial costs of hospitalizations and medical care~~hospitalization, surgery, and medical treatment and care~~. The Plan may also include, but is not required to include, prescription drugs~~prescribed drugs, medicines~~, prosthetic appliances, hospital inpatient and outpatient service Benefits, dental Benefits, vision care Benefits, and other types of medical ~~expense and medical expense indemnity~~ Benefits. The Plan shall be designed to:

1. Provide ~~a reasonable relationship between the~~ hospital, surgical, and medical benefits with cost sharing of expenses for to be included and the expected distribution of expenses of each such type to be incurred by the Enrolled Members covered Employees, and 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 Sspouses 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~~Employee's~~ Sspouse and Dependent children and for discontinuance and resumption by eligible Members ~~Employees~~ of Coverage for the Sspouse, Surviving Sspouse, and Dependents; to adopt and promulgate regulations to establish and define terms and conditions for former and terminated eligible Member~~Employee~~ participation; adopt and promulgate rules and regulations which define the conditions under which eligible Members~~Employees~~ 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~~Subscriber~~ Premium Rates.** The Board shall establish Member~~Subscriber~~ Premium Rates for each Coverage Tier and 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

~~De~~duction amount. Other ~~MemberSubscriber P~~remium amounts shall be established in accordance with these regulations. All ~~Enrolled MemberSubscriber P~~remium ~~R~~ates shall be established by resolution and shall remain in effect until changed by resolution.

1. **Tobacco Surcharge.** ~~An Enrolled MemberA-Subscriber~~ may be charged a tobacco surcharge in an amount approved by the Board if either the ~~Enrolled MemberSubscriber~~ 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'sSubscriber's~~ base monthly Premium. Any ~~Enrolled MemberSubscriber~~ 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 MemberA-Subscriber~~ may be charged a spousal surcharge in an amount approved by the Board if the ~~Enrolled MemberSubscriber~~ elects to cover his or her ~~S~~spouse and the ~~S~~spouse is eligible for ~~health benefits coverage~~ through his or her employer but opts not to take ~~those benefits that coverage~~. Notwithstanding the foregoing, if the ~~S~~spouse is already eligible for ~~C~~overage with the SHBP through his or her employment, and the ~~S~~spouse answered the surcharge question(s) on-line, the SHBP will not add the surcharge to the Premium amount. Any ~~Enrolled Member Subscriber~~ 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 ~~R~~resolution, subject to the Governor's approval, ~~E~~mployer ~~C~~ontribution ~~R~~ates. These rates may be a dollar amount ~~for each Member~~, a dollar amount for each ~~Enrolled MemberEmployee~~, a percentage of ~~Member~~ salary or any other method permitted by law.

1. The ~~E~~mployer ~~C~~ontribution ~~R~~ate for ~~T~~eachers who retired prior to January 1, 1979 shall be a dollar amount as identified in the ~~A~~ppropriations ~~A~~ct.

2. The State Department of Education ~~E~~mployer ~~C~~ontribution ~~R~~ate for the ~~P~~ublic ~~S~~chool ~~E~~mployee ~~H~~health ~~I~~nsurance ~~F~~und shall be a dollar amount as identified in the ~~A~~ppropriations ~~A~~ct.

3. The local school system ~~E~~mployer ~~C~~ontribution ~~R~~ate for the ~~P~~ublic ~~S~~chool ~~E~~mployee ~~H~~health ~~I~~nsurance ~~F~~und shall be a dollar amount per ~~Enrolled Memberactively-enrolled-public-school-employee~~ and shall be remitted to the Administrator on a monthly basis. The ~~E~~mployer's ~~C~~ontribution amount shall be due ~~to the Administrator~~ on the first of the month coincident with the ~~E~~mployees' monthly ~~P~~remium 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 ~~E~~mployer ~~C~~ontribution ~~R~~ate for the ~~T~~eachers ~~H~~health ~~I~~nsurance ~~F~~und 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 ~~E~~mployer ~~C~~ontribution shall be a percentage of

state based salaries. County or district libraries shall pay as the ~~E~~mployer ~~C~~ontribution 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 first of the month~~ coincident with the Employees' monthly ~~coverage~~ Premium amounts payment. The Commissioner is authorized to establish necessary procedures to implement the receipt of the ~~E~~mployer ~~C~~ontribution on a timely and accurate basis.

5. The ~~E~~mployer ~~C~~ontribution ~~R~~ate for the State ~~E~~mployees ~~H~~health ~~I~~nsurance ~~F~~und shall be a percentage of the total salaries of all ~~Members~~ Employees. Total salaries include temporary salaries, overtime pay, terminal leave pay, and all types of supplemental pay. The monthly ~~E~~mployer ~~C~~ontribution shall be based on salaries for the previous month and shall be due on the ~~date first of the month~~ coincident with the Employees' monthly ~~P~~remium 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 ~~R~~egular ~~I~~nsurance 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 ~~B~~enefits 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 ~~C~~overage. 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 ~~P~~lan 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, ~~any public or non-profit critical access hospital~~, the Georgia-Federal State Inspection Service for the inclusion of eligible Members~~Employees~~, retiring Enrolled Members~~Subscribers~~ 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~~Subscriber's~~ salary the Member's~~Subscriber's~~ cost of Ceverage. 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 Ceverage shall be deducted from the Retired Enrolled Member's~~Subscriber's~~ annuity payment. In addition, each Contract Employer shall make the Employer Ceontribution 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~~the Employees~~ and Dependents in the SHBP. Each Contract Employer shall deduct from the Enrolled Member's~~Employee's~~ salary the Member's~~Employee's~~ share of the cost of Ceverage. Each Employer shall remit the total Premium amount as established by the Administrator for inclusion of its Members~~Employees~~ 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 Ceverage for any Group that either contracts for SHBP Ceverage or is designated by applicable state law as eligible for such Ceverage for failure to remit either Employee or Employer Ceontributions.

(ii) **Reinstatement of Coverage.** Upon remittance of the required contributions from any Group that either contracts for SHBP Ceverage or is designated by applicable state law as eligible for such Ceverage, the SHBP may reinstate Ceverage 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 Ceverage.

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 Hhealth Maintenance Organizations.

7. **Local School Systems.** When a school system has elected not to participate in the SHBP for ~~P~~ublic ~~S~~chool 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~~Subscriber ~~P~~remium amounts for the ~~R~~ates established by the Board; and

(ii) Enroll and maintain enrollment at 75% of the eligible ~~P~~ublic ~~S~~chool 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 ~~F~~funds and shall be responsible under a properly approved bond for all monies coming into said ~~F~~funds and paid out of said ~~F~~funds.

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

2. The Commissioner shall establish accounting procedures for maintaining trust ~~F~~funds for the ~~P~~remium income, interest earned on the income and expenses and benefits paid. Any amounts remaining in each trust ~~F~~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 ~~F~~funds shall no longer be available for investment, and when ~~F~~funds are to be withdrawn. The director of the Office of Treasury and Fiscal Services shall deposit the ~~F~~funds in a trust account for credit only to the Plan and shall invest the ~~F~~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 ~~H~~health ~~I~~nsurance ~~F~~fund or ~~F~~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~~prepare 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 ~~E~~Employer ~~C~~Contribution ~~R~~Rate for ~~“single” coverage and an average employer contribution for “family” coverage for each Tier non-Medicare Advantage Medicare+Choice~~ Enrolled MembersSubscribers based on the method specified in Section ~~111-4-1-.02(d)(1)-(5)111-4-1-.11(14) and 111-4-1-.11(16) of these regulations.~~ The Commissioner shall present the ~~E~~Employer ~~HMO~~ ~~C~~Contribution ~~R~~Rates and the ~~Enrolled MemberSubscriber~~ ~~D~~Deduction/R~~eduction~~ amounts for each Option and ~~Coverage~~ Tier to the Board for adoption at least sixty (60) days before the beginning of the State of Georgia’s Fiscal Year.

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

(g) **Develop and Publish Plan Document.** The Commissioner shall ~~cause to be developed~~develop a Summary Plan Description (SPD) or ~~C~~Certificate of ~~C~~Coverage which incorporates the approved schedule of ~~B~~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~~cause the SPD’s Summary Plan Description to be printed and distributed to each local and state ~~E~~Employer ~~for distribution to Enrolled Membersfor each covered Subscriber.~~ The ~~Commissioner or designee~~Commissioner shall ~~cause to~~ distribute the SPD to Retired ~~Enrolled MembersSubscribers~~ and ~~to~~ Extended Beneficiaries at their last known address.

~~(h) **Provide Identification Cards to Subscribers.** The Commissioner shall cause to be designed and printed an identification card for each enrolled Subscriber and dependent, unless the Subscriber has elected coverage under an HMO. The Commissioner is authorized to mail Identification Cards directly to the Subscribers at their home address. The Commissioner may require the Employing Entity to distribute Identification Cards to Subscribers following Open or Special Enrollment periods. The Commissioner shall establish procedures for Subscribers to report dependents and shall acknowledge approval or denial of those dependents to the Subscriber through the Employing Entity. The Commissioner shall require that a Subscriber’s dependents be reported and approved prior to payment of claims on the dependent. The Commissioner shall determine if failure to notify the Administrator of a new dependent within thirty-one~~

~~(31) days after acquisition will eliminate the eligibility of that dependent, who may otherwise be eligible, until the next open enrollment period. If the determination is made to install this provision, Subscribers must be notified in advance and allowed a minimum of sixty (60) days to update their records prior to the implementation of this filing.~~

~~(h)~~ **Provide Notice of Employer Contribution.** The Commissioner shall provide notice and certification of the required ~~E~~mployer ~~C~~ontribution ~~R~~ate to each of the Employing Entities and the Department of Education on or before June 1 of each year, if the ~~R~~ate for the ensuing fiscal year is to be modified. The Commissioner shall notify the Employing Entities before the ~~R~~ate is effective of any ~~R~~ate 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 B~~eneficiaries of the Extended Coverage ~~provisions of Section 111-4-1-.08 of these regulations~~eligibility upon notification by the Employing Entity of the ~~Enrolled Member's~~Subscriber's employment termination, death, or reduced hours or upon notification by the ~~Member~~Subscriber of divorce, legal separation, or child no longer meeting the definition of ~~D~~ependent.

~~(j)~~ **Provide Certification of Creditable Coverage.** The Administrator shall establish procedures for providing a ~~C~~ertificate of ~~C~~reditable ~~C~~overage to each ~~Enrolled Member~~Subscriber at the time ~~C~~overage cancels or upon request of the ~~Member~~Subscriber or Covered Dependent and for a period of twenty-four ~~(24)~~ months after coverage cancellation. The ~~Member~~Subscriber may use the certification to limit a subsequent plan's imposition of a ~~P~~re-existing ~~C~~ondition limitation or exclusion period. Coverage cancellation may be the result of termination of ~~C~~overage through Employee ~~D~~eduction/~~R~~eduction, termination of ~~C~~overage at the end of an ~~A~~pproved ~~L~~ease of ~~A~~bsence ~~W~~ithout ~~P~~ay, or termination of ~~C~~overage at the end of the ~~COBRA~~Temporary 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 ~~C~~overage for a ~~Member~~Subscriber or ~~D~~ependent who has followed all established procedures and met the time deadlines regarding enrollment or maintenance of ~~C~~overage. If the error has placed the ~~Member~~Subscriber or ~~D~~ependent at a substantial financial risk or risk of loss of ~~C~~overage, the facts shall be reviewed and corrective action taken. If the Administrator concludes that the ~~Member~~Subscriber or ~~D~~ependent was substantially harmed, the ~~Member~~Subscriber or ~~D~~ependent 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 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) Electronic Enrollment Process. Each Employing Entity and retirement system is responsible for the timely creation of electronic enrollment system records necessary for the proper administration of their Employee's and Annuitant's eligibility and participation in the SHBP. Failure to add, update or correct employment records may result in the Employee's or Annuitant's loss of eligibility to participate in health Coverage. Failure to provide the Administrator timely confirmation of Member payroll Deductions/Reductions shall result in suspension of Member benefit payments.

(b)(a) Enroll Eligible Employees. Each Employing Entity shall ~~instruct and enroll or~~ assist all persons who become ~~full time Employees and who are~~ eligible to become Enrolled Members under these regulations ~~how to complete the SHBP electronic enrollment or declination process as Subscribers of the SHBP unless the Employee rejects or waives such coverage in writing.~~ The Employing Entity shall require each eligible new ~~Member~~ Employee to complete, within thirty-one (31) calendar days of reporting to work, ~~an electronic request for enrollment in or declination of SHBP Coverage, a form for enrolling or a form for declining or waiving coverage under the SHBP.~~ If an eligible Member is unable to complete the process via the electronic enrollment web site, the Employer shall be responsible for timely completion of the process on behalf of the Member. The Employing Entity shall be responsible for collecting any Premiums due for the selected Coverage.

(c)(b) Deduct Enrolled MemberSubscriber Premium Amounts. The Employing Entity shall withhold the ~~Enrolled MemberSubscriber~~ Premium amount as approved by the Board, or the Premium amount authorized by the applicable Georgia Code sections, from ~~earnedhis/her~~ compensation as the ~~Enrolled Member'sSubscriber's~~ share of the cost of Coverage under the Plan. Any retirement system under which retired or retiring ~~Enrolled MembersSubscribers~~ may continue Coverage under the SHBP as an ~~A~~annuitant shall withhold the Premium amount as approved by the Board from ~~thehis/her~~ annuity as the ~~Enrolled Member'sSubscriber's~~ share of the cost of Coverage under the Plan.

(d)(e) Remit Employee and Employer Amounts. The Employing Entity ~~or retirement system~~ shall reconcile their ~~Enrolled Member'sEmployee's~~ SHBP Coverage records ~~to their payroll records~~ in the manner prescribed by the Administrator. ~~Each Employing Entity and retirement system shall remit and remit the amount of premium deducted from the Subscriber's compensation or annuity~~ within five (5) working days following the effective date of Coverage, ~~an amount equal toThe Subscriber premium remitted by the Employing Entity to the Administrator shall equal~~ the full, face amount of the Premium due for the period coincident with the ~~Enrolled Member'sSubscriber's~~ SHBP Coverage, as reflected on the SHBP monthly billing statement. Each ~~E~~mployer 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~~receipt of the bill. 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'sSubscriber'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 MembersSubscribers who elect to enroll or continue Coverage during an approved fFamily mMedical or Approved Leave of Absence Without Pay.

~~(e)(d)~~**Provide Employee Enrollment Information to the Administrator.** Each Employing Entity shall make available to eligible MembersEmployees all educational and benefit enrollment information necessary for the MemberEmployee or Subscriber to make an informed health benefit plan decision and access the electronic enrollment web site.

~~(f)(e)~~**Provide Plan Materials to Each Eligible MemberEmployee.** Each Employing Entity shall distribute the Summary Plan Description ~~with UPDATER's~~ and electronic enrollment information to each eligible MemberEmployee. Each Employing Entity shall make every effort to distribute other SHBP materials, including Open or Special Enrollment information, ~~identifications cards~~, and information about the web site, to MembersEmployees at the request of the Administrator. When appropriate, each Employing Entity shall hold group meetings to explain a specific aspect of the SHBP to MembersEmployees.

~~(g)(f)~~**Administer Provide Leave Without Pay ProvisionsInformation—to Subscribers.** 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 MembersEmployees. Each Employing Entity shall maintain an Enrolled Member's eligibility within the electronic enrollment system to continue SHBP Coverage under the provisions of these regulations during a period of Approved Leave of Absence Without Pay. Each Employing Entity shall also provide continuation of Coverage electronic enrollment information to MembersSubscribers ~~under other Leave Without Pay provisions of these regulations~~. Each Employing Entity shall insure MembersEmployees on Approved Leave of Absence Without Pay are properly notified of the annual Open Enrollment pPeriod and afforded the opportunity to enroll or change Coverage.

~~(h)(g)~~**Provide Member Loss of EligibilityEmployee Termination 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 andthe date of the last deduction and/or the reason for the loss of employment/eligibilityeoverage termination no later than thirty (30) days following the employment termination or event leading to loss of eligibility to participate in the Plan through payroll Deduction/Reduction. The reasons for loss of eligibilityeoverage termination 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. §§ 45-18-1 *et. seq.*, 20-2-881, 20-2-883, 20-2-884, 20-2-885, 20-2-891, 20-2-892, 20-2-893, 20-2-894, 20-2-895, 20-2-896, 20-2-911, 20-2-912, 20-2-913, 20-2-914, 20-2-915, 20-2-916, 20-2-918, 20-2-919, 20-2-920, 20-2-921, 20-2-922, 20-2-924, 31-5A and 20-2-55, Health Insurance Portability and Accountability Act (HIPAA), Consolidated Omnibus Budget Reconciliation Act (COBRA), Family Medical Leave Act FMLA).

PROPOSED RULE
OF THE
GEORGIA DEPARTMENT OF COMMUNITY HEALTH
RULE 111-4-1-.02

STATEMENT OF PURPOSE AND MAIN FEATURES OF PROPOSED RULE:

The purpose of this proposed rule is to make the rules and regulations consistent with anticipated business operation changes.

DIFFERENCES BETWEEN EXISTING RULE AND PROPOSED RULE:

Errors in capitalization have been made.

Lettering and numbering sequence have been adjusted, as necessary.

In 111-4-1-.02(1)(a), the words “hospitalization and surgical and” that appear immediately before the words “medical insurance” in sentence one (1) have been deleted for the purpose of having more succinct phrasing. Additionally, in that same sentence, the phrase “hospitalization, surgery, and medical treatment and care” that appears behind the words “financial costs of” has been deleted and is replaced by the words “hospitalizations and medical care,” also for a more succinct, clearer read.

In sentence two (2) of 111-4-1-.02(1)(a), the words “prescribed drugs, medicines” will be replaced by the words “prescription drugs,” the common term used for prescribed drugs in the industry; the word “service” has been deleted from the phrase “outpatient service benefits” as it is not necessary to convey the meaning; the conjunction “and” has been inserted in front of the word “other” as a grammatical indicator of the final words in a series; and the words “expense and medical expense indemnity” have been deleted as they are not necessary to convey the intent of the sentence.

In 111-4-1-.02(1)(a)(1), the word “a” and the words “relationship between the” have been deleted as they will no longer be necessary to convey the meaning of the sentence, and the phrase “with cost sharing of expenses for” replaces the phrase “to be included and the expected distribution of expenses of” as the new phrasing more succinctly communicates distribution of costs among Members, Dependents, and the Plan. Also, in that same provision the words “covered Employee” are replaced by the newly defined term “Enrolled Member” as the newly defined term suits the immediate context.

In 111-4-1-.02(1)(a)(2), the word “financial” has been placed in front of the word stability to clarify that financial stability is being referenced in that specific instance.

In 111-4-1-.02(1)(b), either the appropriate singular, plural or possessive form of eligible Member, with “Member” being the newly defined term, or “Enrolled Member,” which is also a newly defined term, replaces the term “Employee,” as the terms “Member” or “Enrolled Member” may be used more appropriately for the context at hand. Additionally, wording has been added stating that the Plan will establish the same rules unless either State or federal law or regulations promulgated by the State of Georgia’s Insurance Commissioner require a modification.

The newly defined term “Member” replaces the alleviated term “Subscriber” in the heading for 111-4-1-.02(1)(c) as an indicator of the contract holder. The newly defined term “Member” also replaces the alleviated term “Subscriber” as an indicator of the contract holder in sentences one (1) and two (2) of 111-4-1-.02(1)(c). Moreover, also in sentence one (1), the words “Tier and” have been eliminated as the word “Tier” will no longer be used in conjunction with the word “Coverage” as it relates specifically to the type of Coverage contract offered.

Throughout 111-4-1-.02(1)(c)(1) either “An Enrolled Member” (with Enrolled Member being the appropriate newly defined term) or “Enrolled Member” replaces “A Subscriber” or “Subscriber” (with Subscriber being the alleviated term).

Throughout 111-4-1-.02(1)(c)(2) either “An Enrolled Member” (with Enrolled Member being the appropriate newly defined term) or “Enrolled Member” replaces “A Subscriber” or “Subscriber” (with Subscriber being the alleviated term). Also, the words “health benefits” replace the word “coverage” and the words “those health benefits” replace “that coverage” in order to clarify that the health benefits at issue are that of an outside employer as opposed to SHBP Coverage.

In 111-4-1-.02(1)(d), the phrase “for each Member” has been inserted in sentence two (2) to clarify that each Member may pay a specified dollar amount for Rates. Additionally, in that same sentence, the appropriate newly defined term “Enrolled Member” replaces the word “Employee,” and the newly defined term “Member” has been inserted immediately before the word “salary” for clarification purposes.

In 111-4-1-.02(1)(d)(3), the words “actively enrolled public school employee” have been replaced with the appropriate newly defined term “Enrolled Member.” The phrase “to the Administrator” has been added to clarify that the monthly Employer’s Contribution must be submitted to the Administrator. Furthermore, a sentence has been added to the end of the subsection authorizing the Commissioner to establish any necessary procedures for implementing the receipt of the Employer Contributions timely.

In 111-4-1-.02(1)(d)(4). The word “Employer’s” has been inserted in front of the word Contribution to clarify who makes the Contribution. The words “first of the month” have been replaced with the word “date” to indicate that the payment will be due on whatever date specified by the Plan, and the words “coverage payment” have been

replaced by the words “Premium amounts” in that Premium is the defined term for such payments.

In 111-4-1-.02(1)(d)(5), the word “Employee” has been replaced with the newly defined term “Member” as appropriate for the context. The words “first of the month” have been replaced with the word “date” to indicate that the payment will be due on whatever date specified by the Plan, and the words “coverage payment” have been replaced by the word “Premium” in that Premium is the defined term for such payments. Finally, language has been added to the provision in order to authorize the Commissioner to establish necessary procedures to facilitate the receipt of the Employer Contribution in a timely manner.

The acronym (“CDHP”) has been placed in a parenthetical following the words “Consumer Driven Health Plans” in 111-4-1-.02(1)(e) so that the acronym may be used throughout the text.

In 111-4-1-.02(1)(e)(3), the newly defined term “Member” or the newly defined term “Enrolled Member” replace the alleviated term “Subscriber” as appropriate throughout the subsection.

In 111-4-1-.02(1)(e)(5), the words “eligible Member” replace the word “Employee” inasmuch as “Member” is the appropriate newly defined term. The word “Contract” has been inserted in front of the word “Employer” as “Contract Employer” is the appropriate defined term. The possessive form of the appropriate newly defined term “Enrolled Member,” which is “Enrolled Member’s” takes the place of the word “Employee’s,” the word Employee’s has been deleted immediately following the word “total,” as it is not a necessary word for the context, and the newly defined term “Members” replaces the word “Employee” as the appropriate defined term.

The alleviated term “Subscriber” has been replaced with the appropriate newly defined term “Enrolled Member” in 111-4-1-.02(1)(e)(7)(i).

The word “Employee” has been replaced with the appropriate newly defined term “Member” in 111-4-1-.02(2)(b)(1).

In 111-4-1-.02(2)(d), the word “prepare” has been deleted and replaced with the words “caused to be prepared” indicating that while the Commissioner will cause the preparation, it will not be the Commissioner’s responsibility to actually prepare the request for proposals.

In 111-4-1-.02(2)(e), cross references to 111-4-1-.11(14) and 111-4-1-.11(16) have been deleted and replaced with the appropriate cross reference, which is 111-4-.02(d)(1) through 111-4-1-.02(d)(5).

In 111-4-1-.02(2)(e), the words “ ‘single’ coverage and an average employer contribution for ‘family’ coverage for” have been deleted and the words “each Tier”

(with “Tier” being the appropriately defined term) have been inserted to indicate the new Rate structure. The words “Medicare+Choice” have been changed to the new name “Medicare Advantage.” The newly defined term “Members” replaces the alleviated term Subscriber. The words “of these regulations” after 111-4-1-.11(16) for clarification purposes. Additionally, the alleviated term “Subscriber” has been replaced with the newly defined term “Enrolled Member” where appropriate and the word “Coverage” has been deleted immediately before the word “Tier” in that Coverage Tier is no longer a defined term. The word “sixty” is spelled out and the number “60” placed in a parenthetical for the purpose of consistency.

The appropriate newly defined term “Member” replaces the alleviated term “Subscriber” in 111-4-1-.02(2)(f).

Language has been added to 111-4-1-.02(2)(g) that the Commissioner will cause the development of the SPDs and that the Commissioner or the Commissioner’s designee(s) will cause the distribution of the SPDs. Language as also been added to clarify that the distribution will be to “Enrolled Members.”

The former 111-4-1-.02(2)(h), “Provide Identification Cards to Subscribers,” has been deleted in its entirety as it is no longer applicable for the current business operations. “Provide Notice of Employer Contribution” has been re-lettered and is the new 111-4-1-.02(2)(h).

In the new 111-4-1-.02(2)(i), the word “Extended” has been inserted immediately before the word “Beneficiary” as “Extended Beneficiary” is the appropriate defined term. The words “provisions of Section 111-4-1-.08 of these regulations” has been added as a cross reference to Extended Coverage provisions. The newly defined terms “Enrolled Member” and “Member” replace the alleviated term “Subscriber” where appropriate.

In the new 111-4-1-.02(2)(j), the newly defined terms “Enrolled Member” or “Member” replace the words “Employee” and the alleviated term “Subscriber” as appropriate. The number “24” is placed in a parenthetical following the word “twenty-four” for consistency purposes. The acronym “COBRA” is placed in front of the words “Extended Coverage” to make specific reference to the COBRA law.

In the new 111-4-1-.02(2)(k), the newly defined term “Member” replaces the alleviated term “Subscriber” where appropriate.

A new subsection has been added at 111-4-1-.02(3)(a), detailing the Employing Entity’s responsibility in the electronic enrollment process under the SHBP’s new eligibility system. A failure to update a Member’s eligibility may result in suspension of benefit payments.

Wording was added to 111-4-1-.02(3)(b) detailing the new electronic enrollment process for SHBP Members as a result of the SHBP’s new eligibility system (using the newly defined terms “Member” or “Enrolled Member,” as appropriate). This new system

requires an electronic request or declination of SHBP enrollment coverage. If the Member cannot complete the electronic enrollment process, the Employer shall assume responsibility for its completion on behalf of the Member.

The newly defined term “Enrolled Member” replaces the alleviated term “Subscriber” in the heading or text of the new 111-4-1-.02(3)(c) as appropriate. The word “the” has been inserted and the words “his/her” have been deleted from sentence one (1) and the word “earned” was placed in front of the word “compensation” for clarification purposes.

Wording has been added to the new 111-4-1-.02(3)(d) to indicate that retirement systems must also reconcile the Enrolled Member’s Coverage records to payroll records. Each Employing Entity and retirement system must remit the appropriate Premium amounts timely. The appropriate form of the newly defined term “Enrolled Member” replaces the words “Employee” and the alleviated term “Subscriber” as necessary and appropriate in this subsection. Also, wording has been added to indicate that billing invoices will be monthly and that each Employer will be responsible for corrections to the records prior to the Coverage effective date and that reconciliation must be completed within thirty (30) days of the billing invoice.

In 111-4-1-.02(3)(d)(1), the newly defined term “Member” replaces the alleviated term “Subscriber.” “Leave Without Pay” has been made to read as “Approved Leave of Absence Without Pay,” which is the appropriate defined term.

In the new 111-4-1-.02(3)(e), the newly defined term “Member” replaces the words “Employee” or “Subscriber” as appropriate, and the words “and access the electronic enrollment web site” have been added to indicate that Employing Entities need to make this feature available to SHBP Members.

In the new 111-4-1-.02(3)(f), the words “Eligible Member” (which appears in the heading) or the newly defined term “Member” replaces the word “Employee” as appropriate. Also, the reference to distribution of identification cards is stricken as it will not be the business operation. The words “with UPDATER’s” and “identification cards” have been omitted as they are not necessary.

The words “Administer” and Provisions” have been added to the heading of the new 111-4-1-.02(3)(g). A reference to the administration of “Approved Leave of Absence Without Pay” has been inserted into the first sentence along with the conjunction “and” connecting the words to the Family Medical Leave “Act.” The newly defined term “Member” replaces the words “Employee” or “Subscriber” as appropriate. A requirement has been added that each Employing Entity maintain Enrolled Members’ eligibility within the electronic enrollment system in order to continue SHBP Coverage on an Approved Leave of Absence Without Pay. The phrase “under Approved Leave of Absence Without Pay” has been eliminated as it is no longer necessary to convey the provision’s intent and meaning.

The words “Employee Termination” have been stricken and the words “Member Loss of Eligibility” have been added to the heading in the new 111-4-1-.02(3)(h) in order to more clearly convey the intent of the provision. Wording has been both added and deleted to convey the meaning that Employing Entities shall report to the Administrator through electronic interface files or data entry into the electronic enrollment web site the last date of employment or eligibility of Members. The word “COBRA” has been inserted clarifying that any penalties assessed the Administrator as a result of the Employing Entity’s failure to remit terminate dates will be passed on to the Employing Entity.

The Health Insurance Portability and Accountability Act (HIPAA), Consolidated Omnibus Budget Reconciliation Act (COBRA,) and Family Medical Leave Act(FMLA) have been added as citing authorities to the end of this subsection.

111-4-1-.03 General Provisions.

(1) **Applicability.** All ~~Employees~~Members who become eligible for ~~C~~coverage under the SHBP shall be enrolled or permitted to change Coverage ~~electionTier or Option~~ only in accordance with these regulations. ~~All~~ Employing Entities covered by the Acts shall administer the SHBP in accordance with these regulations. ~~All~~ ~~A~~annuitants or Extended Beneficiaries shall be enrolled or permitted to change Coverage ~~electionTier or Option~~ only in accordance with these regulations.

(2) **Extension of SHBP to Eligible Groups.** The Board shall review and approve provisions for extending ~~C~~coverage to eligible ~~G~~groups as required by law. The special provisions may include allowing ~~Members~~Employees or ~~B~~beneficiaries to reenroll in the SHBP.

(3) **Conformity with Federal Requirements.** When federal law is enacted requiring public employers to comply with certain requirements for continued receipt of public health or other grant funds, the Commissioner shall submit proposed regulations to the Board for approval.

(4) **Records.** The Plan records shall be maintained in accordance with applicable State and federal law and regulations, including, but not limited to, Chapter 33 of Title 31 of the Georgia Code and the privacy regulations promulgated under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Records which are not private, confidential or otherwise excluded from disclosure shall be available for public inspection and copying, in accordance with the Georgia Open Records Act. Any medical records and other individually identifying health information presented to the Administrator or to any of the Third Party Administrators in the ~~C~~claim adjudication process or medical review process shall be confidential and shall be accessible only in accordance with applicable State and federal law and regulations.

(5) **MemberSubscriber Responsibility.** The ~~MemberSubscriber~~ has responsibility for notifying ~~thehis/her~~ Employer and the Plan of discrepancies in the ~~Member'sSubscriber's~~ ~~C~~coverage records. Notwithstanding ~~the foregoing~~, the requirements of this provision do not negate the ~~E~~mployer's responsibility. The Employing Entity must still fulfill notification and all other requirements set forth under these regulations.

(a) The ~~Enrolled MemberSubscriber~~ is responsible for assuring that the proper ~~P~~remium payments are deducted or reduced from the ~~Enrolled Member'sSubscriber's~~ salary or retirement benefit for the ~~Option and Coverage Tier~~ that ~~the Enrolled Memberwas~~ selected. Premiums of ~~Enrolled MembersSubscribers~~ that are paid through direct pay are to be paid in accordance with their ~~C~~coverage selection. ~~For the State Fiscal Year 2006 plan year (July 1, 2005, through December 31, 2005), non-retiree subscribers will be required to select Option and Coverage Tier electronically. For this plan year only, the Commissioner may permit subscribers who failed to do so one additional opportunity to select Option and Coverage Tier.~~

(b) The Enrolled Member is responsible for submitting such documentation as the Plan requires to verify the eligibility of Dependents to be added to Coverage within the timeframe allotted by the Plan. Any Dependents not verified within the Plan's allotted time shall not be eligible for Coverage until the next annual Open Enrollment period or subsequent Qualifying Event as described in these regulations.

~~(c)(b)~~ The Enrolled MemberSubscriber is responsible for updating ~~S~~spouse and ~~D~~ependent information and requesting appropriate changes in Coverage as the circumstances may warrant. The Enrolled MemberSubscriber shall reimburse the Plan in full for Claim liability and expenditures incurred by the Plan on behalf of a Dependent who does not meet the definition of an eligible Dependent under these regulations. Any refunds of Premiums (for reasons other than administrative error) will be limited to twelve (12) calendar months from the date that the Administrator receives evidence from the Enrolled MemberSubscriber that the Plan had no liability for additional covered persons.

~~(d)(e)~~ When the Enrolled MemberSubscriber desires to reduce the period under the insurance Options of limited Coverage for Pre-existing conditions which may apply to himself/herself or any Covered Dependent, the Enrolled Membermember shall provide the Administrator certification of prior Creditable Coverage from the appropriate ~~group~~ health plan administrator.

(6) **Gender and Number.** Except when otherwise indicated by the context, any masculine terminology herein shall also include the feminine and the definition of any terms herein of the singular may also include the plural.

Authority O.C.G.A. Secs. 20-2-881, 20-2-894, 20-2-897, 20-2-911, 20-2-922, 20-2-925, 45-18-1 et seq., 50-18-72, 50-18-94, Health Insurance Portability and Accountability Act (HIPAA). **History.** Original Rule entitled "General Provisions" adopted. F. Apr. 18, 2005; eff. May 8, 2005. **Amended:** ER. 111-4-1-0.1-.03 adopted. F. June 13, 2005; eff. June 16, 2005, as specified by the Agency. **Amended:** Permanent Rule adopted. F. Sept. 15, 2005; eff. Oct. 5, 2005.

PROPOSED RULE
OF THE
GEORGIA DEPARTMENT OF COMMUNITY HEALTH
RULE 111-4-1-.03

STATEMENT OF PURPOSE AND MAIN FEATURES OF PROPOSED RULE:

The purpose of this proposed rule is to make the rules and regulations consistent with anticipated business operation changes.

DIFFERENCES BETWEEN EXISTING RULE AND PROPOSED RULE:

Errors in capitalization have been corrected.

Throughout this subsection, the appropriate forms (singular, plural, or possessive) of the newly defined terms “Member,” or “Enrolled Member” replace the words “Employee” or “Subscriber,” as necessary and appropriate.

Any grammatical error(s) have been corrected.

In 111-4-1-.03(1), the word “election” replaces the words “Tier or Option” as those words will no longer be used in these regulations in conjunction with the word “Coverage” in the context at hand.

In 111-4-1-.03(5), the word “the” replaces “his/her” as a grammatical/styling choice and the words “the foregoing” have been inserted immediately behind the word “Notwithstanding” for clarification purposes..

In 111-4-1-.03(5)(a), references to “Option” or “Tier” have been eliminated in that the terms are no longer necessary for the context at hand. Also, the last two sentences of the provision have been deleted in their entirety inasmuch as they applied to the specified past time period of July 1, 2005 to December 31, 2005.

A provision has been added at 111-4-1-.03(5)(b) holding the Enrolled Member responsible verification of Dependent eligibility. Failure to verify may result in a loss of Dependent Coverage until the next annual Open Enrollment period or subsequent Qualifying Event.

In the new 111-4-1-.03(5)(c), the word “may” has been inserted in front of the word “warrant” to clarify contingency of circumstances. Additionally, the word “twelve”

has been spelled out in front of the number “12,” which has been enclosed in a parenthetical for consistency purposes.

The word “group” has been eliminated from 111-4-1-.03(5)(d) as it is not necessary to convey the intent or meaning of the sentence.

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 ~~s~~Secretaries and ~~l~~aw ~~c~~lerks 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. ~~Public School Employees Retirement System.~~—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. ~~Non-Certificated Public School Employees.~~—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~~~~Subscriber~~ premium and employer contribution amounts shall be in accordance with O.C.G.A. § 20-2-55 and these regulations.

(2) **Retired ~~Employees~~Subscriber.** 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~~~~Subscriber~~ 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~~~~Subscriber~~ 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~~~~Subscriber~~ and a Dependent.** In the situation where both husband and wife are eligible to be covered under the SHBP as ~~an Enrolled Member~~~~Subscriber~~, each may enroll as a ~~Member~~~~Subscriber~~ 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-Subscriber Limited.** In the situation where the ~~Enrolled MemberSubscriber~~ is entitled to ~~C~~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 ~~MemberSubscriber~~ may choose among the ~~A~~active ~~Employee~~ provisions under which the ~~MemberSubscriber~~ will be covered, but may not choose ~~C~~coverage as a Retiree or ~~B~~beneficiary of a Retiree as long as the ~~MemberSubscriber~~ is eligible for ~~C~~coverage under one of the ~~A~~active ~~Employee~~ provisions. In no circumstance shall the individual be ~~an Enrolled Membera coveredSubscriber~~ 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:In the situation where the Subscriber is eligible for coverage under the SHBP as an Active Employee of two (2) separate employing entities, the Employee may, during the Open Enrollment period, elect which Employing Entity shall deduct the appropriate premium for coverage.~~

(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 pPeriod, 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 ofeligible to participate in~~ the SHBP may continue the Coverage ~~Tier and Option~~ in which enrolled during a period of “~~A~~approved ~~L~~leave of ~~A~~absence ~~W~~without ~~P~~pay”, subject to the conditions in these regulations. ~~Enrolled~~ Employees who are on suspension or ~~A~~approved ~~L~~leave of ~~A~~absence ~~W~~without ~~P~~pay ~~who did not continue Coverage~~ shall not be eligible to enroll or re-enroll for ~~C~~coverage while on ~~Approved LLeave of Absence Wwithout Ppay~~ under any provision of these regulations except during the annual Open Enrollment period. Except for ~~m~~Military ~~I~~leave and ~~Military Reservist Activation Leave, C~~coverage shall not be extended for ~~an Employeea Subscriber~~ who is self employed or gainfully employed by another party during a period of ~~Approved LLeave of Aabsence Wwithout Ppay~~. ~~A requestApplication~~ to continue ~~C~~coverage while on ~~Approved LLeave Wwithout Ppay~~ must be ~~signed within thirty-one~~

~~(31) days and filed with~~ received by the Administrator within thirty-one (31) calendar ~~sixty (60)~~ days of the termination of paid Ceoverage through payroll Deductions. EmployeesSubscribers who qualify for continued Ceoverage under multiple leave types may continue Ceoverage under a combination of leave types; however, the total period of Ceoverage 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 Ceoverage between termination of paid Ceoverage through payroll Deductions and the beginning of Approved Leave of Absence Wwithout Pay Ceoverage. When an Employee on Approved Leave of Absence Without Pay enrolls during the annual Open Enrollment, Period the twelve (12) calendar month Ceoverage 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 ~~d~~Disability LLeave is the period of time ~~for which the Employee has been granted~~ an Approved Leave of Aabsence Wwithout 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 coveragehealth benefits under this provision.

~~1.—Certification of the disability period by a licensed physician shall be required to continue health benefits under this provision; and~~

~~2.—The Administrator shall be empowered to require additional information from the certifying physician or require a review by another physician, if the disability period is longer than the medically accepted standard for the diagnosis.~~

(b) **Reduced Working Hours Due to Partial Disability.** A Partial Disability leave is the period of time during which an Subscriber whose Eemployer approves an Employee'shis return to work on a part-time basis from a period of disability leave or paid leave ~~may be eligible to continue coverage~~ if the part-time work is part of a process to gradually return the EmployeeSubscriber 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 coveragehealth benefits under this provision.

~~1.—Certification of the partial disability period shall be required to continue health benefits under this provisions; and~~

~~2.—The Administrator shall be empowered to require additional information from the certifying physician or require a review by another physician, if the disability period is longer than the medically accepted standard for the diagnosis.~~

(c) **Leave of Absence for the Employer's Convenience.** ~~A leave of absence for the E~~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 officialthe employer, pursuant to appropriate regulation, places an Employee on approved leave of

~~absence without pay~~ due to a regular programmatic plan for Employee absence and pursuant to appropriate regulation. The Employee may continue the Coverage ~~Tier and Option under~~ 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 EmployeeSubscriber may continue the Coverage ~~Tier and Option~~ under such leave for the period of absence, but not longer than twelve (12) consecutive calendar months.

(e) **Family Medical Leave.** Family medical ~~Leave for purposes of continued health benefit coverage~~ 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 ~~Leave Without Pay~~ for family medical leave ~~Family Leave~~ may be continued for the period of approved leave, but not longer than twelve (12) weeks in any twelve (12) consecutive month period. ~~Coverage extension also shall be subject to the following conditions:~~

~~1.—The employer must provide notification to the Plan that the Subscriber has been approved for family leave for the purpose of child birth, adoption, or placement. Notification must include the period, the reason, and the date of birth, or placement of a child for adoption or foster care.~~

~~2.—The employer must provide notification to the Plan that the Subscriber has been approved for family leave as a result of the Subscriber's serious illness or a family member having a serious illness. Notification must include a certification by an appropriate attending medical provider that outlines the disability period required for the Subscriber's recuperation from serious illness or the required period(s) for caring for a seriously ill spouse, child, or parent.~~

~~3.—Disability periods that extend beyond the time allowed for Family Medical Leave may be approved under the provisions of the "Disability Leave" of these regulations, provided the Subscriber and employer fully comply with the documentation and certification requirements.~~

(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. The EmployeeSubscriber may continue the Coverage ~~Tier and Option~~ under such leave for the period of absence, ~~but not longer than twenty-four (24) consecutive calendar months.~~

~~(g)—**Military Reservist Activation Leave.** Military Reservist Activation Leave is the period of time during which an Employee is activated to military duty. The Subscriber~~

~~may continue the Coverage Tier and Option under such leave for the period of absence for persons whose health benefit coverage through payroll deductions ceases after July 1, 1990.~~

~~g(h)~~ **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 ~~A~~approved ~~L~~leave of ~~A~~absence ~~W~~without ~~P~~pay ~~has been~~is granted by the appropriate organization official for the Employee's convenience. The ~~EmployeeSubscriber~~ may continue the Coverage ~~Tier and Option~~ for the period of suspension or approved leave, but not to exceed twelve (12) calendar consecutive months, provided the ~~EmployeeSubscriber~~ is not self employed or gainfully employed by another party during such leave of absence.

~~h(i)~~ **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. The Subscriber must sign the extension request no later than thirty one (31) days following expiration of coverage under the approved leave of absence, have the Employing Entity certify approval of the extension, have the attending physician complete the disability certification if a "disability" leave, and file the request with the Administrator within sixty (60) days of the previously expired leave of absence coverage.

~~i(j)~~ **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.

~~(k)~~ **Recurrent Periods of Leave.** ~~Recurrent periods of leave of absence without pay for the same or related illness shall be considered one (1) approved leave period unless the Subscriber returns to work and has coverage through payroll deductions for a period of three (3) consecutive calendar months.~~

~~(l)~~ **Administrative Requirements.** ~~The Administrator shall develop procedures and forms for assuring compliance with these provisions. These procedures shall include:~~

~~1.—An application form for continuing benefits that briefly outlines the requirements of these regulations and requires certification of the approved leave by the appropriate organizational official; and~~

~~2.—Notification to the Subscriber that timely payment is required for continued coverage, the date payment is due, that a fee established by the Administrator will be assessed for late payments or payments which are not honored by the drawer's bank, and that coverage will be terminated if timely payment is not received.~~

~~(j)(m)~~ **Premiums.** Premiums for continued ~~C~~coverage during a period of Approved Leave of Absence Without Pay~~leave of absence~~ shall be paid monthly. When

establishing the monthly ~~P~~remium amount to be paid by the ~~E~~mployee~~S~~ubscriber, the Board may add a processing fee. The ~~P~~remium ~~R~~ate, excluding the processing fee, shall be based on the type of approved leave. The ~~P~~remium ~~R~~ate for ~~d~~isability, ~~f~~amily ~~l~~ease or ~~m~~military ~~R~~eservist ~~A~~ctivation leave of absence shall be the same as the Employee ~~D~~eduction; the ~~P~~remium ~~R~~ate for all other types of leave shall be the total amount, which consists of the Employee ~~D~~eduction and average ~~E~~mployer ~~C~~ontribution. Failure to pay the full Premium as billed within the allotted time shall result in suspension of benefit payments and/or termination of Coverage until the Employee returns to work.

(7) **Spouse.** An Active Employee shall be entitled to enroll the Employee's ~~S~~pouse upon employment, during Open Enrollment, or under conditions specified in Section 111-4-1-.06 of these regulations. A ~~R~~etiree~~R~~etired ~~S~~ubscriber shall be entitled to continue ~~C~~overage for the ~~S~~pouse upon retirement or may enroll the ~~S~~pouse 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 ~~D~~ependent children upon employment, during Open Enrollment, or under conditions specified in Section 111-4-1-.06 of these regulations. A ~~R~~etiree~~R~~etired ~~S~~ubscriber shall be entitled to continue ~~C~~overage for eligible ~~D~~ependent children upon retirement or may enroll eligible ~~D~~ependent children in accordance with Sections 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 ~~D~~ependent 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 ~~E~~nrolled ~~M~~ember's~~S~~ubscriber's home one hundred eighty (180) days or more per year in a parent-child relationship. Eligibility begins on the later of ~~the date family coverage becomes effective, 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 ~~E~~nrolled ~~M~~ember's~~S~~ubscriber'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 ~~r~~esident in the ~~E~~nrolled ~~M~~ember's~~S~~ubscriber's home in a parent-child relationship and is legally certified as a ~~D~~ependent of the ~~E~~nrolled ~~M~~ember~~E~~mployee-~~(R~~etiree) 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. ~~H~~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 ~~MemberSubscriber~~ or living natural parent(s).

(9) **Full-time Student.** An eligible ~~D~~ependent child may be included under the ~~Enrolled Member'sSubscriber's~~ Coverage ~~by enrollment, extension or re-enrollment~~ while a full-time student in ~~F~~ull-~~T~~ime ~~A~~ttendance at an ~~A~~ccredited ~~S~~chool 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 ~~C~~overage as a temporarily ~~D~~isabled ~~S~~tudent 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.—The Administrator shall require documentation of temporary disability no later than ninety (90) days form the later of the date of temporary disability or the date on which approved coverage ends.

(b) The Administrator shall require appropriate documentation to demonstrate ~~F~~ull-~~T~~ime ~~A~~ttendance~~/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-~~C~~overage.

(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 the next Open Enrollment period under the SHBP or until the occurrence of a subsequent Qualifying Event.

~~(10)(11)~~ **Totally Disabled Child.** ~~An Enrolled MemberA Subscriber~~ shall be entitled to apply for continuation of ~~C~~overage 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 MemberSubscriber~~ or is institutionalized and depends primarily~~is primarily dependent~~ on the ~~Enrolled MemberSubscriber~~ for support and maintenance.

(a) **Application Period.** The Enrolled Member~~Subscriber~~ must apply for continuation of ~~C~~overage and include all supporting documentation prior to the end of the month in which the child reaches age nineteen (19) or loss of continuous Coverage as a full-time student nder this Plan, no later than ninety (90) days following the child's

~~nineteenth (19th) birthday or loss of continuous coverage as a full-time student under this Plan.~~ If the ~~Enrolled MemberSubscriber~~ fails to complete the request within the allotted time apply for continued coverage within ninety (90) days of the nineteenth (19th) birthday, eligibility for Ceverage is limited to the conditions outlined for full-time students or Extended Beneficiaries. If, however, the Dependent child was eligible for Ceverage under the SHBP as a disabled Dependent upon reaching age nineteen (19), ~~an Enrolled MemberSubscriber~~ shall be entitled to apply to enroll the disabled Dependent upon loss of other group plan Ceverage, 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 application is filed with the SHBP no later than ninety (90) days following loss of other group plan coverage or loss of continuous Ceverage 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'sSubscriber'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.

~~(11)(12)~~ **Surviving Beneficiary.** ~~An Enrolled Member'sA-Subscriber's~~ Surviving ~~beneficiaries,~~ Sspouse and eligible Dependent children, who were included in the Ceverage by the ~~Enrolled MemberEmployee or Retired Employee~~ may continue Ceverage provided an application for continuing Ceverage is received by the Administrator within thirty-one (31) calendar ninety (90) days following Ceverage termination as a result of the death of the ~~Enrolled MemberSubscriber~~ and one or more of the following conditions are met:

(a) The Surviving Sspouse of an Aactive Employee may continue Ceverage provided the Sspouse is eligible to immediately receive a monthly benefit payment from a state supported retirement system in an amount sufficient to pay the Premium. The Sspouse may elect Ceverage as a Surviving Sspouse or as an Employeea-Subscriber as a result of the Sspouse's own employment, but cannot elect double or dual Ceverage under separate provisions of the SHBP. The Surviving Sspouse may elect to continue Ceverage for surviving eligible Dependent children. Eligibility of Dependent children shall terminate in accordance with provisions for Dependent children of these regulations. Note Aan election to take a lump sum distribution rather than the monthly Annuity negates eligibility to continue Ceverage as a Surviving Sspouse. 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 Ssurviving Sspouse of an Annuitanta-Retired-Employee may continue Ceverage provided the Sspouse is eligible to immediately receive a monthly benefit payment from a state supported retirement system in amount sufficient to pay the Ppremium. The Sspouse may elect Ceverage as a Ssurviving Sspouse or as an Employeea-Subscriber as a result of the Sspouse's own employment, but cannot elect double or dual Ceverage under separate provisions of the SHBP. The Ssurviving Sspouse may elect to continue Ceverage for surviving eligible Ddependent children. Eligibility to continue Ddependent children shall terminate in accordance with provisions for Ddependent children.

(c) Upon the death of an Aactive Employee, an eligible Ddependent child who is the principal Bbeneficiary under one of the state supported retirement systems may continue Ceverage, provided the Ddependent child is not covered as a Ddependent 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 Ppremium. Eligibility to continue Ceverage shall terminate in accordance with Ddependent 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. Coverage under the Extended Beneficiary provision shall be limited to thirty-six (36) months following death of the active Employee, inclusive of coverage months under this provision.

(d) Upon the death of a Retired Employee, an eligible Ddependent 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 cChildren.

~~(e) 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).~~

~~(f)~~(e) The Ssurviving Sspouse of Retired Employee who is included in Ceverage at the time of death of the enrolled RetireeSubscriber 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'sSubscriber's Ddependent children at the time of the Retiree'sSubscriber's death under the following conditions:

1. The Ssurviving Sspouse must make written application no later than thirty-one (31) calendar ninety (90) days following Ceverage termination as a result of the death of the Retired EmployeeSubscriber; and
2. The parties must have been married at least one full year prior to the death of the Retired EmployeeSubscriber; and
3. The Ssurviving Sspouse agrees to pay the monthlyquarterly premium payment established by the Board in accordance with the established requirements; and

4. Coverage under this provision shall terminate for the Ssurviving Sspouse and any enrolled Ddependent children in the event the Ssurviving Sspouse 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.

(12)(14) **Retired Employees Having Intermittent Periods of Active Employment.** Retired Employees who are eligible to continue Ceverage under these regulations may elect to return to or continue Aactive employmentservice 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 Ceverage must be purchased as an Aactive Employee whenever the eligibility requirements of Section 111-4-1-.04 of these regulations are met. At the point the Employee discontinues Aactive employment, continuous service and returns to retired status, health benefit Ceverage shall bemaay be, upon notification to the Plan, reinstated with the state supported retirement system which previously collected the Premiuecontinuous coverage under the conditions which first made the Employee eligible as a Retiree. In no case, however is an individual who retired prior to the initial legislated funding for that Ggroup of Employees to be entitled to enroll as a Retiree, unless the final Aactive service period qualifies the Employee for a retirement benefit by one of the state supported retirement systems.

~~(13)~~(15) **Judicial Reinstatement of State Employees.** State Employees who are reinstated to employment by the State Personnel Board or the judiciary shall have Ceoverage reinstated for themselves and any eligible De 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 reimbursementprocessing. If back-pay to provide for continuous employment is not awarded, Ceoverage may be reinstated with the Employee'sSubscriber's return to work. If reinstatement occurs following a period longer than twelve (12) calendar months after the discharge, Ceoverage for the EmployeeSubscriber and previously Covered Dependents will be reinstated when the EmployeeSubscriber 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~~thirty-one (31)~~ days after reinstatement to modify Ceoverage in compliance with Open Enrollment guidelines. Pre-existing condition limitations will be waived for the reinstated EmployeeSubscriber and all previously enrolled De dependents. Employing Entities shall be responsible for collecting and remitting any Premiums due for the selected Ceoverage.

~~(14)~~(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. Secs. 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. **History.** Original Rule entitled "Eligibility for Coverage" adopted. F. Apr. 18, 2005; eff. May 8, 2005.

PROPOSED RULE
OF THE
GEORGIA DEPARTMENT OF COMMUNITY HEALTH
RULE 111-4-1-.04

STATEMENT OF PURPOSE AND MAIN FEATURES OF PROPOSED RULE:

The purpose of this proposed rule is to make the rules and regulations consistent with anticipated business operation changes.

DIFFERENCES BETWEEN EXISTING RULE AND PROPOSED RULE:

Errors in capitalization have been corrected.

Lettering or numbering has been re-sequenced as necessary and appropriate.

Throughout this subsection (in both headings and throughout the text), the appropriate forms (singular, plural, or possessive) of the newly defined terms “Member,” or “Enrolled Member” replace the words “Employee” or “Subscriber,” as necessary and appropriate (with the article “an” preceding the defined term where appropriate).

The heading at 111-4-1-.04(1)(c)(1) has been deleted for formatting consistency.

In the heading of 111-4-1-.04(2), the word “Employees” replaces the alleviated term “Subscriber” as the appropriately used word in the immediate context.

The heading at 111-4-1-.04(1)(c)(2) has been deleted for formatting consistency.

At 111-4-1-.04(2)(a), the defined term “Retired Employee” replaces the alleviated term “Subscriber” indicating that the subsection applies to Retired Employees as opposed to Active Employees.

At 111-4-1-.04(2)(b), the defined term “Retired Employee” replaces the alleviated term “Subscriber” indicating that the subsection applies to Retired Employees as opposed to Active Employees.

The term “Employee” has been inserted behind the term “Active” throughout 111-4-1-.04(4) for clarification purposes.

With the exception of the heading, all of the existing wording has been deleted from 111-4-1-.04(5). One sentence has been added following the heading. The sentence

reads as follows: “Dual eligibility and overlapping coverage shall be handled as follows: “; the purpose of the sentence is to introduce the new subsections 5(a) and 5(b), “Dual Eligibility” and “Overlapping Coverage,” respectively.

A new subsection entitled “Dual Eligibility” has been added at 111-4-1-.04(5)(a). Wording has been added under that subsection stating that if an Enrolled Member is eligible for Coverage as an Active Employee for two Employing Entities, he or she may elect which Employing Entity deducts the Premium. Both Employing Entities will remit Employer Contributions.

A new subsection entitled “Overlapping Coverage” has been added at 111-4-1-.04(5)(b) stating that if a Member experiences overlapping Coverage as a result of transferring between two Employing Entities, the Coverage effective date with the second Employer determines the Coverage termination date with the first employer. The Employing Entity will have the responsibility for determining and refunding Premiums.

In 111-4-1-.04(6) the proposition “of” follows the inserted newly defined term “Enrolled Member” to give clear meaning to the revised sentence one (1). Additionally, the words “eligible to participate in” have been deleted from that sentence because they are not necessary to convey the meaning of the sentence. Also, language has been added at 111-4-1-.04(6) stating that Employees who decline continuation of Coverage during an Approved Leave of Absence Without Pay will not be eligible for Coverage until the next Open Enrollment period. Throughout the subsection, words have been added to make the words “leave without pay” the defined term “Approve Leave of Absence Without Pay.” The words “and Military Reservist Activation Leave” have been deleted inasmuch as the preceding words “Military Leave” encompass all forms of military service. The words “an Employee” have been inserted to replace the alleviated term “Subscriber” in this specific context. The word “Application” has been replaced with the words “A request,” in an effort to communicate the meaning more clearly. The words “signed within thirty-one (31) days and filed with” have been replaced with the words “received by” for succinctness, and the reference to “sixty (60) days” has been changed to “thirty-one (31) calendar days,” reducing the length of time a request may be received. Finally, in the last sentence of the provision, the words “elect to” have been inserted in front of the words “participate in the SHBP” for clarity of meaning.

In 111-4-1-.04(6)(a), the words “for which the Employee has been granted” have been deleted and the words “has been granted to the Employee” have been inserted in an effort to convey the meaning of the sentence more clearly. Wording similar to the former 111-4-1-.04(6)(a)(1) has been added to the provision at 111-4-1-.04(6)(a), stating that a licensed physician must certify the disability period for continuation of Coverage. The former 111-4-1-.04(6)(a)(1) has been deleted in its entirety inasmuch as the gist of the meaning has been communicated at 111-4-1-.04(6)(a).

The former 111-4-1-.04(6)(a)(2) has been deleted as its inclusion is not necessary for current operations.

Additional wording has been added at 111-4-1-.04(6)(b) to clarify what constitutes a Partial Disability. The words “may be eligible to continue coverage” have been deleted as they are not necessary to convey the meaning of the sentence. Wording similar to the former 111-4-1-.04(6)(b)(1) has been added to 111-4-1-.04(6)(b), stating that certification of the Partial Disability period shall be required to continue Coverage under this provision of these regulations. The former 111-4-1-.04(6)(b)(1) has been deleted in its entirety.

The former 111-4-1-.04(6)(b)(2) has been deleted as its inclusion is not necessary for current operations.

In 111-4-1-.04(6)(c), wording has been added to clarify the meaning of Employer’s Convenience Leave (and unnecessary words have been deleted). Also, wording has been added to suggest that such leave will be handled in accordance with the appropriate regulations. Finally, the words “Tier and Option” have been deleted so that the newly defined term “Coverage” remains.

In 111-4-1-.04(6)(d), the words “Tier and Option” have been deleted so that only the newly defined term “Coverage” remains.

Throughout 111-4-1-.04(6)(e), the word “Medical” has been placed in between Family and Leave so that the words read together as “Family Medical Leave.” The words “for the purposes of continued health benefit Coverage” and “to the Employee” have been deleted inasmuch as they are not necessary to communicate the clear intent of the sentence. In the next to last sentence, the words “Leave Without Pay” have been replaced with the defined term “Approved Leave of Absence Without Pay” and the word “consecutive” has been placed in front of the word month clarifying that the twelve (12) month period cannot be interrupted. The last sentence of this provision has been deleted because the conditions that it references will no longer be applicable.

Provisions 111-4-1-.04(6)(e)(1)-(3) have been deleted as they will no longer be necessary conditions for the Plan’s operations.

In 111-4-1-.04(6)(f), wording has been added to further clarify how the Plan defines military leave. The words “Tier and Option” have been deleted, leaving the newly defined term “Coverage.” And the twenty-four (24) consecutive calendar month requirement has been deleted as the twenty-four (24) month limitation will not apply.

The former 111-4-1-.04(6)(g) has been deleted in its entirety as the previous provision on Military Leave at 111-4-1-.04(6)(f) encompasses Military Reservist Activation Leave.

A portion of the new 111-4-1-.04(6)(g) has been reworded for a clearer read (but the meaning has been left unchanged).

A portion of the new 111-4-1-.04(6)(h) has been reworded for a clearer read (but the meaning has been left unchanged).

The former provisions 111-4-1-.04(6)(k)(1)-(2) have been deleted as they will not be applicable to Plan operations.

In the new 111-4-1-.04(6)(j), the words “leave of absence” have been changed to the defined term “Approved Leave of Absence Without Pay.” The words “Reservist Activation” have been deleted in “Military Reservist Activation Leave” because “Military Leave” will also encompass Reservist Activation leave. Additionally, language has been added stating that failure to pay the Premium within the allotted time will result in suspension of benefit payments and termination of Coverage until the Employee returns to work.

In 111-4-1-.04(7), the defined term “Retired” replaces “Retired Subscriber.” Additionally, language has been added stating that the Administrator shall require appropriate documentation to demonstrate a Spouse’s eligibility for Coverage.

In 111-4-1-.04(8), the defined term “Retiree” replaces “Retired Subscriber.” Additionally, language has been added stating that the Administrator shall require appropriate documentation to demonstrate a Dependent’s eligibility for Coverage.

In 111-4-1-.04(8)(c), the phrase “family coverage becomes effective, the date” is deleted inasmuch as it is not necessary to convey the clear intent of the provision.

In 111-4-1-.04(8)(d), the phrases “the earlier of the” and “or the expiration date specified in the court order” have been inserted into sentence one to clarify that Coverage for a legally certified Dependent as a result of a Guardianship will terminate the earlier of age nineteen (19) or when the court order expires. A phrase has been inserted stating that eligible Dependents on TriCare supplement may continue Coverage until age twenty-three (23), as stipulated by TriCare (as opposed to the Plan’s general limit of twenty-six (26)).

In 111-4-1-.04(9), the phrase “by enrollment extension or re-enrollment” has been deleted from sentence one as it is not necessary to convey the meaning of the sentence. Wording has been added to the end of the provision stating that failure to document Dependent eligibility and Full-time Attendance prior to loss of Coverage shall result in the loss of the Dependent’s eligibility for Coverage until the next Open Enrollment period or subsequent Qualifying Event.

In 111-4-1-.04(9)(a), the word “consecutive” has been inserted to indicate that the twelve (12) month time period must be uninterrupted. Additionally, documentation of temporary disability must be received by the Administrator no later than thirty-one (31) calendar days following the date of temporary disability as opposed to the previous ninety (90) day requirement, which has been deleted from the provision.

In 111-4-1-.04(9)(b), the word “nineteen” has been spelled out and the number (19) placed in a parenthesis, and the word “twenty-six” has been spelled out and the number (26) placed in a parenthesis for consistency purposes.

A new subsection entitled “Failure to Document Eligibility for Coverage” has been added at the newly numbered 111-4-1-.04(10) stating that for categories at 111-4-1-.04(7) through 111-4-1-.04(9), a failure to fully document eligibility of a Dependent shall result in loss of the dependent’s eligibility for Coverage until the next Open Enrollment period under the SHBP or until occurrence of a subsequent Qualifying Event.

In the newly renumbered 111-4-1-.04(11) the words “primarily dependent” have been replaced by the words “depends primarily” for the purpose of succinctness.

In the newly renumbered 111-4-1-.04(11)(a), language has been added stipulating that the Enrolled Member must submit all supporting documentation for continuation of Coverage for a Dependent child before the end of the month in which the child reaches age nineteen (19), deleting the previous requirement of submission of the information no later than 90 days after the child turns 19. Additionally, the language is changed from allowing application for a disabled Dependent’s Coverage no later than 90 days after loss of another group health plan to no later than thirty-one (31) calendar days following loss of group plan coverage.

Reference to months have been clarified to be “Calendar” months in the newly renumbered 111-4-1-.04(11)(b) for clarification purposes.

Language is added to the newly renumbered 111-4-1-.04(12) requiring receipt by the Administrator of a Surviving Spouse’s or eligible Dependent children’s request for continuing Coverage within thirty-one (31) calendar days following Coverage termination as a result of the death of an Enrolled Member, deleting the ninety (90) day requirement. (In addition to “Employee,” “Retired Employee” has also been deleted and replaced by the newly defined term “Enrolled Member” in this provision).

Language has been added to 111-4-1-.04(12)(a) stating that eligibility of Dependent children shall terminate in accordance with provisions for Dependent children, and also that Surviving Spouses of Active Employees will also be eligible for Coverage under the Extended Beneficiary provisions at 111-4-1-.08 of the regulations.

The words “an Annuitant” replace the words “Retired Employee” inasmuch as the term Annuitant may be used appropriately in this context.

The words “an Employee” are appropriate to replace the alleviated term “Subscriber” in 111-4-1-.04(12)(b).

Language has been added to 111-4-1-.04(12)(c) stating that surviving Covered Dependents of Active Employees are also eligible for Coverage under the Extended Beneficiary provisions at 111-4-1-.08 of the regulations. The reference to limiting

Beneficiary Coverage to thirty-six (36) months has been eliminated as the Extended Beneficiary provisions are covered in 111-4-1-.08(a) of the regulations.

The former 111-4-1-.04(11)(e), which would have been renumbered as 111-4-1-.04(12)(e) has been deleted in its entirety as it will not be the business operation requirement.

References to a “Subscriber” have been changed to the defined term “Retiree” or “enrolled Retiree” in the new 111-4-1-.04(12)(e).

The time period for a Surviving Spouse to make written application for Coverage following the death of a Retired Employee has been changed from ninety (90) days to thirty-one (31) calendar days in 111-4-1-.04(12)(e)(1).

In 111-4-1-.04(12)(e)(3), the requirement for quarterly Premium payments by Surviving Spouses has been changed to monthly Premium payments.

New language has been added at 111-4-1-.04(12)(f) stating that Dependents of an Active State Employee killed or injured while acting in the scope of employment may continue Coverage provided the Employee had continuous Coverage as either a surviving Dependent or Employee as a result of the person’s own employment (but cannot elect dual Coverage under the SHBP). If Coverage is elected, the monthly Premium must be paid and any Dependent children’s Coverage will terminate in accordance with the regulation provisions for Dependent children.

New language has been added at 11-4-1-.04(12)(g) stating that the Surviving Spouse must list all eligible Dependents with the Administrator at the time of the election for continuation Coverage and will not be able to add another Spouse or other Dependent children acquired by future marriages(s).

New language has been added at 111-4-1-.04(13) stating that supporting documentation verifying Dependent status must be received by the Administrator within thirty-one (31) calendar days of the later of the date of request of the Qualifying Event that allows the inclusion of the Dependent for Coverage. If the Dependent cannot be verified, he or she will be ineligible for Coverage.

In the newly renumbered 111-4-1-.04(14), the word “employment” replaces the word “service” as an indication of Active work status. Words have been inserted to clarify that the federal Social Security Act requires health benefit Coverage be purchased as an Active Employee when the requirements of 111-4-1-.04 of these regulations are met. Words have been added and deleted to clarify that when an Employee discontinues Active employment, continuous health benefit Coverage will be reinstated with the state supported retirement system that previously collected the Premium.

In the newly renumbered 111-4-1-.04(15), references to months or days have been clarified as “calendar” months or days. The words “remitted to the Plan before” have

been added for clarification purposes and the word “reimbursement” replaces the word “processing” for clarity of meaning. After judicial reinstatement, an Employee will now have fifteen (15) calendar days, as opposed to the deleted thirty-one (31) days to modify Coverage compliance with Open Enrollment guidelines. In the last sentence, the words “and remitting” have been added for clarification purposes.

111-4-1-.05 Effective Date of Coverage.

(1) **Upon Employment.** The Employee's Coverage under the SHBP shall become effective on the first of the month following employment for the full preceding calendar month if the Employee has not terminated employment on or before that date. Coverage for a transferring Employee shall be effective the first of the month following the end of Coverage under a previous Employing Entity. Coverage for eligible Dependents will become effective on the date the Employee's family Coverage is effective.

(2) **Upon Change in Coverage.** If the MemberEmployee changes Coverage to include eligible Dependents based upon acquisition of Dependent(s), Coverage for the Dependents shall become effective on the later of the first of the month following the request for Coverage, or subject to guidelines for acquisition of Dependent(s).

(3) **Upon Open Enrollment Change or Enrollment.** The effective date for enrollments or changes in Coverage electionTier to add eligible dependents shall be JanuaryJuly 1st unless the Member no longer meets the definition of an Active Employee employment terminated on or before that date. The termination date for Open Enrollment discontinuation of Coverage shall be December 31st. Subject to the provisions of Section 111-4-1-.06 of these regulations, Coverage elections shall be binding upon the Member for the duration of the Plan Year.

(4) **Upon Return from Leave Without Pay.** The effective date for re-enrollments following an Approved Lease of Absence Without Pay shall be the first of the month following the return to work. The effective date for re-enrollments following a military Lease or Military Reservist Activation Lease without pay shall be the first of the month following the return to work or the date employment is reinstated. In all instances, the appropriate Premiums must be deducted and remitted by the Employing Entity with the next SHBP monthly billing statement.

(5) **Upon Acquisition of a Dependent.** The effective date of Coverage for acquired Dependents is subject to the requirements as outlined for the MemberEmployee and shall be the later of the first of the month following the request for Coverage or:

(a) **Legally Married Spouse.** The effective date of Coverage shall be no earlier than the first of the month date of marriage to the MemberEmployee. The Plan is not responsible for payment of the Spouse's medical services incurred prior to the actual date of the marriage.

~~(b) **Common Law Spouse.** The effective date of coverage shall be the date as documented that the common law marriage began, provided that it began prior to January 1, 1997. The Administrator shall define the necessary documentation, such as evidence of joint purchase of a home, or joint bank accounts to substantiate the common law marriage.~~

~~(e)~~(b) **Natural Children.** The effective date of Coverage shall be the date of birth.

~~(d)~~(c) **Stepchildren.** The effective date of Coverage shall be no earlier than the date of marriage of the ~~Member~~Employee and the natural parent of the children or the date that the stepchildren began living in the home of the ~~Member~~Employee, if later than the date of parental marriage.

~~(e)~~(d) **Adopted Children.** The effective date of Coverage shall be no earlier than the date of placement specified in the adoption contract. Coverage may be granted based on the date of legal placement and physical custody.

~~(f)~~(e) **Other Children.** The effective date of Coverage shall be the first of the month in which the court approves legal guardianship.

(f) **Full-time Student Children.** The effective date of Coverage shall be no earlier than the first of the month of documented Full-time Attendance at an Accredited School.

(6) **Premium.** The Administrator shall suspend Coverage of Enrolled Members and Covered Dependents for which the Plan has not received full payment of the required Premium prior to the first day of the Coverage month. Suspended Coverage will be reactivated upon receipt of full payment of the required monthly Premium.

Authority O.C.G.A. Secs. 20-2-881, 20-2-911, 45-18-2, Health Insurance Portability and Accountability Act (HIPAA), Internal Revenue Code Section 125, Uniformed Services Employment and Reemployment Act 5. **History.** Original Rule entitled "Effective Date of Coverage" adopted. F. Apr. 18, 2005; eff. May 8, 2005.

PROPOSED RULE
OF THE
GEORGIA DEPARTMENT OF COMMUNITY HEALTH
RULE 111-4-1-.05

STATEMENT OF PURPOSE AND MAIN FEATURES OF PROPOSED RULE:

The purpose of this proposed rule is to make the rules and regulations consistent with anticipated business operation changes.

DIFFERENCES BETWEEN EXISTING RULE AND PROPOSED RULE:

Errors in capitalization have been corrected.

Letter or number re-sequencing has been done as necessary and appropriate.

Throughout this subsection, the appropriate forms (singular, plural, or possessive) of the newly defined terms “Member,” or “Enrolled Member” replace the words “Employee” or “Subscriber,” as necessary and appropriate.

In 111-4-1-.05(1) the word “family” is deleted before the term “Coverage” because the presence of the words “eligible Dependents” in the sentence indicate family Coverage.

In 111-4-1-.05(3) the former use of the term “Tier” has been replaced with the word “election,” as Tier will not be used in the context at hand. January 1st replaces July 1st as the last day to add eligible Dependents, as the Plan Year now currently begins January 1st, provided the Member meets the definition of an Active Employee. Language has also been added indicating that Coverage elections shall be binding until the end of the Plan Year, currently December 31st.

In 111-4-1-.05(4), the words “leave of absence without pay” have been replaced with the defined term “Approved Leave of Absence Without Pay.” “Military Reservist Activation Leave without pay” has been deleted inasmuch as the words Military Leave capture reservist activation leave. Finally, the words “with the next SHBP monthly billing statement” have been deleted as they are not necessary to convey the meaning of the sentence.

Language has been revised at 111-4-1-.05(5)(a) indicating that Coverage for legally married Spouses shall begin no earlier than the first of the month of the marriage.

The SHBP will not provide payments for medical services of the Spouse incurred prior to the date of the marriage.

Language concerning common law spouses has been deleted in its entirety at 111-4-1-.05(5)(b) as it will not be the Plan's policy.

New language has been added at 111-4-1-.05(5)(f) indicating that the effective date of Coverage for full-time students shall be no earlier than the first of the month of documented attendance at an Accredited School.

Language has been added at 111-4-1-.05(6) indicating that benefit Coverage will be suspended if the full Premium payment is not received by the first day of the Coverage month. Coverage will be reactivated upon receipt of the required monthly Premium payment.

111-4-1-.06 Changes in Coverage and Option.

(1) **Open Enrollment Period and Retiree Option Change Period.** The Open Enrollment ~~p~~Period and Retiree Option ~~c~~Change ~~p~~Period shall be a minimum period of fifteen (15) calendar days ~~each year~~ and shall begin no earlier than ~~October 1~~ April 15 and shall end no later than ~~November 15~~ May 31 of each year. The Commissioner shall announce the dates of the periods each year. Eligible Employees, enrolled Retirees and Extended Beneficiaries shall be given an opportunity to make the changes in Ccoverage election as reflected in the following paragraphs.

(a) **Active Employees.** Eligible Aactive Employees, eligible Employees on Approved Lease of Absence Without Pay and Extended Beneficiaries shall be given an opportunity to enroll or change Coverage ~~Tier and Options~~ during the Open Enrollment ~~p~~Period. ~~For the State Fiscal Year 2006 plan year (July 1, 2005, through December 31, 2005), non-retiree subscribers will be required to select Option and Coverage Tier electronically. For this plan year only, the Commissioner may permit subscribers who failed to do so one additional opportunity to select Option and Coverage Tier.~~

(b) **Retirees.** During the Retiree Option Change Period, enrolled Retirees shall be given an opportunity to change Coverage Option to any ~~regular insurance Option. The Retiree may also change to any HMO Option for which the Retiree is eligible by virtue of the Retiree's residence and/or Medicare enrollment.~~

(2) **Returning Employee from an Approved Leave of Absence.** ~~The An eligible Employee who did not continue Coverage during an Approved Leave of Absence Without Pay which included the Open Enrollment period shall be offered the opportunity to enroll, discontinue, or change Coverage Tier and Option within fifteen (15) calendar thirty one (31) days of the date the Employee returns to work.~~

(3) Qualifying Event During a Period of Ineligibility. ~~When an Employee loses eligibility for Coverage and subsequently resumes eligibility for Coverage within the same Plan Year, and a Qualifying Event under these regulations occurs during the period of ineligibility, the Employee shall have the opportunity to request a change in Coverage election for the remainder of the Plan Year that is consistent with that Qualifying Event. The request to change Coverage election must be received by the Administrator within thirty-one (31) calendar days following the date the Employee resumes eligibility through an Employing Entity. The effective date of the requested action shall be consistent with the new employment provisions of these regulations. The Administrator shall request supporting documentation to demonstrate the Qualifying Event has occurred. Failure to fully document the occurrence of the Qualifying Event within the allotted time shall result in reversal of the new Coverage election and restoration of the Employee's former Coverage election.~~

(4) Retired Employee's Discontinuation of Coverage. ~~A Retired Employee may discontinue Coverage at any time by advance notice to the Administrator without any entitlement to re-enroll at a later date.~~

~~(3)~~(5) **Reinstatement of Employee Across Plan Years.** If an Employee was reinstated to employment for a period of time inclusive of the applicable Open Enrollment period, the Employee shall be offered the opportunity to enroll or change Coverage ~~Tier and Option~~ within fifteen (15) calendar~~thirty-one (31)~~ days of the return to work.

~~(4) **Enrollment Other than Open Enrollment.** When an active Employee's spouse, enrolled dependent, or an active Employee, loses or discontinues health benefit coverage through other employment, Medicaid or Medicare, the Employee may enroll for single or family coverage, provided application to enroll is filed no later than thirty-one (31) days following the date medical coverage terminated with that employer, Medicaid or Medicare.~~

~~(5)~~(6) **Qualifying Life Event Coverage Changes**~~Coverage Changes Other than Open Enrollment or Retiree Option Change Period.~~ A Member~~Subscriber~~ shall be eligible to change Coverage election~~Tier and Option~~ as outlined in these regulations. Requests to enroll, change, or discontinue coverage must be received by the Administrator~~filed~~ no later than thirty-one (31) calendar days following the qualifying event, ~~unless otherwise noted in the specific provision.~~ The effective date of the Coverage election change or discontinuation shall be the first of the month following receipt of the request, unless otherwise noted in these provisions. The Administrator shall request supporting documentation to demonstrate the Qualifying Event has occurred. Failure to fully document the occurrence of the Qualifying Event within the allotted time shall result in reversal of the Coverage election and restoration of the Member's prior Coverage election.

(a) **Marriage Resulting in Dual Coverage.** When an Enrolled Member~~a Subscriber~~ marries and becomes eligible through the new spouse's employment, the Enrolled Member~~Subscriber~~ may discontinue coverage or decrease Coverage Tier~~change to single coverage~~, provided that all enrolled persons under the Enrolled Member's~~Subscriber's~~ contract are covered under a group health benefit plan, ~~and provided the request for the change or discontinuance is filed no later than thirty-one (31) days following the qualifying event.~~ Documentation of enrollment under the other employer's group health benefit plan shall be required by the Administrator.

(b) **Acquisition of a Dependent.** ~~When the Subscriber Eligible Members may elect Coverage or increase Tier for themselves and all of their eligible Dependents when they acquires a dependent through marriage, birth, or adoption, or legal guardianship a change to "family" Coverage Tier is permissible.—When an eligible Employee acquires a dependent through marriage, birth, or adoption, enrollment is permissible.—If a Member's~~Subscriber's eligible Dependent child assumes or resumes full-time student status, the acquisition of a Dependent definition is fulfilled. Coverage effective dates for the Dependent(s) are established in accordance with Section 111-4-1-.05 of these regulations. Documentation of Dependent(s) eligibility for Coverage shall be required.

(c) **Loss of Other Coverage.** An Enrolled Member may change Coverage under the SHBP when he or she loses membership under some other group health benefit plan as a result of divorce, legal separation, or death. When an Enrolled Member~~a Subscriber~~ or

~~an Enrolled Member's Subscriber's Spouse loses Coverage through employment, the Enrolled Member may increase Tier a change to "family" Coverage Tier is permissible. When an Active Employee, an Employee's Spouse, or any eligible Dependent loses or discontinues enrollment under a group health benefit plan through other employment, or under Medicaid or Medicare, the Employees may enroll themselves and any eligible Dependents in SHBP Coverage. Loss of the other coverage membership under another group health benefit plan through employment can be the Member's Subscriber's, Spouse's or former Spouse's change in employment status affecting eligibility for group health benefit plan membership coverage under a Cafeteria Plan or other qualified health benefit plan, the former Spouse's refusal to continue covering health benefits forage on the Dependent children, an Approved Leave of absence Without Pay by the Spouse or former Spouse resulting in termination of group health benefit plan membership coverage or no Employer's Contribution to the Premium, or the termination of the Member's Subscriber's, Spouse's, or former Spouse's group health plan through his or her employment by his/her employer, or the termination of (COBRA) coverage. The Administrator shall require documentation to substantiate the loss of coverage. Documentation of the loss of membership under another group health benefit plan, or under Medicaid or Medicare, shall be required by the Administrator.~~

(d) **Loss of Dependents.** ~~When an Enrolled Member a Subscriber loses all Dependents through one of the following: (1). divorce; (2). death; (3). legal separation; or (4). the loss of eligibility of an only Covered Dependent who no longer meetsing the definition of an eligible Dependent, a change in coverage from "family" to "single" Tier is permissible, provided the Subscriber files a request to change no later than ninety (90) days following the qualifying event the Administrator shall decrease the Member's Tier. An Enrolled Member may request a decrease in Tier. Loss of all dependents also applies when a Qualified Medical Child Support Order ("QMCSO"); judgment, decree or order resulting from a divorce, legal separation, annulment, or change in legal custody requires a former Spouse to provide health Coverage for the Member's Subscribers' Covered enrolled Dependents; documentation of the order and Dependent Coverage under another health plan shall be required. No refund of Premiums will be allowed for this decrease in Tier change.~~

(e) **Birth of Dependent.** ~~A Member A Subscriber, except as provided in Section 111-4-1-.08 of these regulations, may enroll themselves and all their eligible Dependents in Coverage or increase Tier change from "single" to "family" Coverage Tier within thirty-one (31) days following the birth of the child. The effective date of the Coverage change shall be the first of the month following the request unless the Member specifically elects to include the newborn in Coverage from the date of birth. When the Member elects to include the newborn from the date of birth the effective date of the Coverage change shall be the first of the month of birth. In cases where the requested change is filed no later than thirty one (31) days after birth, appropriate premiums may be collected by the Employing Entity from the Subscriber to backdate family coverage to the first of the month in which the child was born. The Administrator shall require that payment of the appropriate Premiums for prior months of Coverage be collected from the date the Member elects for the Coverage to become effective. Coverage effective dates for the dependent(s) are established in accordance with Section 111-4-1-.05. This provision~~

allows other eligible Dependents to be enrolled for Coverage subject to the eligibility and Coverage effective date rules in Sections 111-4-1-.04 and 111-4-1-.05 of these regulations. Documentation of the new Dependent's birth and all other Dependents' eligibility for Coverage shall be required.

(f) **Change in Employment Status.** An ~~A~~active Employee may ~~decrease~~change to ~~single~~ Coverage Tier or discontinue ~~C~~coverage when the ~~S~~spouse's or only ~~Covered~~~~enrolled~~ ~~D~~ependent's employment status changes and affects the individual's eligibility under a ~~C~~ cafeteria ~~P~~lan or other qualified health benefit plan and all covered persons removed from the contract are covered under the other employer's group health benefit plan. ~~The application for change or discontinuance must be filed no later than thirty one (31) days following the date that the Subscriber, spouse, or dependent first becomes eligible for coverage.~~ The Administrator shall require documentation of the ~~coverage under the~~ other group health benefit plan enrollment. ~~The effective date of the~~ ~~c~~Change in Coverage ~~Tier~~ or discontinuation shall be the latter of the first of the month following receipt of the request or approved no earlier than the date that the ~~Employee~~~~Subscriber~~ and ~~Covered~~~~SHBP~~ ~~enrolled~~ ~~D~~ependents are covered under the other group health benefit plan.

(g) **Qualified Medical Child Support Order (QMCSO).** ~~An eligible Member~~~~A~~ ~~Subscriber~~ will be enrolled or have their~~changed to "family" Coverage~~ Tier increased upon determination by the Administrator that a court or administrative order, judgment or decree is a QMCSO~~qualified medical child support order~~ for a natural child of an eligible Member~~A~~ ~~Subscriber~~. The Administrator shall notify the ~~Member~~~~Subscriber~~ parent, each alternate parent based on information contained in the order, and the Employing Entity of the receipt of such order. The Administrator shall establish procedures in compliance with federal and State ~~L~~aw for processing the enrollment or change of coverage action. Enrollment or an increase of a~~change to family Coverage~~ Tier under this paragraph shall not be subject to any timely filing requirements. A ~~Member~~~~Subscriber~~ who is the recipient of such order may not discontinue coverage for the dependent child unless there is documentation that the order is rescinded or the child is covered by the ~~Member~~~~Subscriber~~ under other health insurance on or after the date of coverage discontinuance under the Plan. The Administrator shall require appropriate documentation for discontinuance of coverage for a ~~Member~~~~Subscriber~~ or alternate Subscriber who is the recipient of the QMCSO. An Enrolled Member with a QMCSO shall be allowed to change from an HMO Option to a Regular Insurance Option upon request and shall not be subject to any timely filing requirements.

(h) **Spouse or Employee Military Reservist Activation Period.** An eligible ~~Employee~~~~A~~ ~~Subscriber~~ may enroll or increase or decrease~~change Coverage~~ Tier as a result of the Employee's or ~~S~~spouse's activation into the military service. Upon employment reinstatement following a period of activation, the ~~Employee~~~~Subscriber~~ or ~~S~~spouse may reverse the earlier decision as a result of the activation. The Administrator shall require appropriate documentation of the requested ~~C~~coverage action and the activation or reinstatement no later than thirty-one (31) calendar days following the ~~Q~~qualifying ~~E~~vent.

(i) **Retired Employees.** Married ~~enrolled Retirees~~Retired Subscribers may change ~~coverage Tier~~ in order to become ~~individual Enrolled Members~~from family to each having single Coverage Tier at any time when no individuals other than the Spouse are enrolled in the Coverage. The change in ~~Ce~~coverage will be effective within two (2) calendar months following ~~the Administrator's notice of~~ the requested change.

(j) **Eligible for Medicare or Medicaid.** ~~Enrolled Members~~Subscribers may ~~decreasechange to single Coverage~~ Tier within thirty-one (31) calendar days of all Covered Dependents becoming enrolled in Medicare or Medicaid~~coverage~~. Enrolled Members who have no Covered Dependents~~Subscribers enrolled in single Tier~~ may discontinue ~~Ce~~coverage within thirty-one (31) calendar days of becoming enrolled in Medicare or Medicaid~~coverage~~.

(k) **Change to Family at Time of Involuntary Separation.** When ~~an Enrolled Member~~a Subscriber is involuntarily separated, ~~an increase in a change to family Coverage~~ Tier is allowed at the time of retirement, provided the ~~Member~~Subscriber will immediately begin drawing a monthly benefit from a participating retirement system. The Administrator shall require documentation to substantiate the involuntary separation.

(l) **Spouse's Open Enrollment Change.** Eligible Employees may enroll, ~~decreasechange to single~~ Tier, or discontinue ~~Ce~~coverage when the ~~Employee's~~Subscriber's ~~Spouse~~ makes an ~~Oopen~~ Enrollment change in enrollment status coverage under ~~a non-participatingan~~ employer's ~~provided Ce~~afeteria Plan or other qualified health benefit plan that creates an overlap or gap in group health coverage as a result of the other group plan coverage having a different ~~plan~~ year. The effective date of the Coverage actionenrollment, change, or discontinuation shall be the later of the first of the month following receipt of the request or the effective date of the other group coverage. The Administrator shall require documentation to substantiate that the Spouse's election meets the criteria of this provision.

~~(6) Option Changes Other Than Open Enrollment or Retiree Option Change Period.~~ ~~The Subscriber shall be eligible to change Options under the following conditions, provided the request is completed prior to the event or within thirty-one (31) days following the event.~~

(m)(a) **Managed Care Plan OptionsHealth Maintenance Organization Options (HMO).** An Enrolled Member~~A Subscriber, except as provided for in Section H11-4-1-.06(7);~~ may change to, among, or from a Managed Care Planan HMO when:

1. ~~The Subscriber no longer resides or works within the HMO's approved geographic area and upon approval by the Administrator;~~ The Enrolled Member changes residency to a location that is no longer considered a part of the Managed Care Plan's network of providers contracted with the SHBP;

2. ~~The Subscriber is unable for a cause beyond the Subscriber's control to enroll or to change enrollment within the prescribed time limits upon approval by the Administrator;~~

32. The HMO ceases its operation for any reason, substantially decreases the number of medical care providers available, or ceases offering a Medicare Advantage~~Medicare+Choice managed-care~~ Option in the geographic area. In such case, the Employing Entity of Administrator shall automatically change the Employee's Coverage Option to an Option designated by the Administrator~~the PPO-Basic or other designated~~ Option, unless the Enrolled Member~~Subscriber~~ discontinues Coverage or chooses another Coverage Option for which the Member~~Subscriber~~ is eligible within thirty-one (31) days of the Qualifying Event~~event~~;

43. The Centers for Medicare & Medicaid Services cancels an Enrolled Member's~~sa Subscriber's~~ Coverage in a Medicare Advantage~~Medicare+Choice~~ Option. In such case, the Administrator shall change the Member's~~Subscriber's~~ coverage to PPO-Basic or other designated Option unless the Enrolled Member~~Subscriber~~ chooses another Option for which the Member~~Subscriber~~ is eligible within thirty-one (31) days of the Qualifying Event~~event~~.

(n)(b) **Option Changes for Retirees.** An enrolled Retiree~~A Subscriber~~ may change to any Option to which the Retiree~~Subscriber~~ is eligible upon occurrence of one or more of the following events, provided the request is received by~~selection form is filed with~~ the Administrator within thirty-one (31) calendar days following the Qualifying Event~~event~~:

1. At the time of retirement;
2. At the time that the annuity amount to be received from a state supported participating retirement system becomes insufficient to satisfy the Option premium; or
3. At the time that the Retired Member~~Subscriber~~ becomes eligible for Medicare coverage.

~~(c) **Option Changes at the Loss of Other Coverage.** A Subscriber may change to any Option upon loss of other coverage as outlined in Section 111-4-1-.06(4)(c) or loss of other coverage as a result of divorce, legal separation or death, provided the selection is filed within thirty-one (31) days of the qualifying event.~~

~~(d) **Qualified Medical Child Support Order (QMCSO).** A Subscriber will be allowed to change from an HMO Option to any Option for which the Subscriber is eligible to participate upon determination by the Administrator that a court or administrative order is a qualified medical child support order for a natural child or a Subscriber, when the child lives outside the HMO service area. A change in Option shall not be subject to any timely filing requirements.~~

~~(e) **Option Changes at Change of Residence.** A Subscriber may change to any Option for which the Subscriber is eligible or discontinue when the Subscriber, Subscriber's spouse or enrolled dependent changes residence to an area that is not served by the Option in which the Subscriber is enrolled.~~

~~(7) **Discontinuance of Coverage.** An Active Employee may discontinue coverage in any Option when the Subscriber acquires new coverage under the spouse's employer's plan or as otherwise outlined in these regulations. The effective date of such~~

~~discontinuance shall be on June 30th for discontinuances during open enrollment and as specified by the Administrator for other changes. A Retired Subscriber may discontinue coverage at any time by advance notice to the Administrator, without any entitlement to re-enroll at a later date.~~

(7) **Documentation.** The Administrator may require documentation that a Qualifying Event permitting enrollment, change or discontinuation of Coverage has in fact occurred outside the annual enrollment period. When required, documentation appropriate to the event will be specifically described and must be received by the Administrator within the allotted time. Failure to document appropriately or within the allotted time shall result in the reversal of the requested Coverage action and restoration of the Member's prior Coverage.

Authority O.C.G.A. Secs. 20-2-295, 20-2-881, 20-2-894, 20-2-897, 20-2-911, 20-2-922, 45-18-1 et seq., 50-18-72, 50-18-94, ~~Internal Revenue Code~~~~Treasury Regulation~~ Section 125 – Family and Medical Leave Act of 1993 (FMLA), Consolidated Omnibus Budget Reconciliation Act (COBRA), IRS Code Section 125, Health Insurance Portability and Accountability Act (HIPAA), Child Support Performance and Incentive Act, U.S.E.R.R.A. **History.** Original Rule entitled “Changes in Coverage and Option” adopted. F. Apr. 19, 2005; eff. May 8, 2005. **Amended:** ER. 111-4-1-0.1-.06 adopted. F. June 13, 2005; eff. June 16, 2005, as specified by the Agency. **Amended:** Permanent Rule adopted. F. Sept. 15, 2005; eff. Oct. 5, 2005.

PROPOSED RULE
OF THE
GEORGIA DEPARTMENT OF COMMUNITY HEALTH
RULE 111-4-1-.06

STATEMENT OF PURPOSE AND MAIN FEATURES OF PROPOSED RULE:

The purpose of this proposed rule is to make the rules and regulations consistent with anticipated business operation changes.

DIFFERENCES BETWEEN EXISTING RULE AND PROPOSED RULE:

Errors in capitalization have been corrected.

Letters or numbers have been re-sequenced as necessary.

Throughout this subsection, the appropriate forms (singular, plural, or possessive) of the newly defined terms “Member,” or “Enrolled Member” replace the words “Employee” or “Subscriber,” as necessary and appropriate. (An article such as “a” or “an” may precede the defined term as necessary).

References to Tier and/or Option have been eliminated when used in conjunction with the word “Coverage,” inasmuch as the defined term for that particular context is “Coverage.”

Grammatical errors have been corrected.

In 111-4-1-.06(1), the word “calendar” has been inserted in front of the word days for clarification purposes, and the words “each year” have been deleted as they are not necessary to convey the meaning of the sentence. Furthermore, the dates for Open Enrollment have been changed from no earlier than April 15 ending no later than May 31 to no earlier than October 1 ending no later than November 15. Finally, the word “election” has been inserted behind the word “Coverage” for clarification purposes.

In 111-4-1.06(1)(a), the last two sentences have been deleted inasmuch as they applied to the time period from July 31, 2005 to December 31, 2006, which has already passed.

In 111-4-1.06(1)(b), the word “Coverage” is placed immediately behind the word “change.” Thereafter, the words “Option,” “regular insurance Option,” and “The Retiree may also change to any HMO” have been deleted such that the remaining words communicate the meaning that the Retiree may change Coverage to any Option for which

the Retiree is eligible. Additionally, the words “by virtue of the Retiree’s residence and/or Medicare enrollment” have been deleted as they are not necessary to convey the meaning of the sentence.

In 111-4-1-.06(2), the words “An eligible” are inserted in front of the word Employee for clarification purposes. Also, a phrase has been added to clarify that the Employee should be one who did not continue Coverage during an Approved Leave of Absence that included the Open Enrollment period. Additionally, the word “discontinue” has been inserted to indicate that the Employee will also have the opportunity to discontinue Coverage. Finally, language has been added that any changes must be made within fifteen (15) calendar days of the Employee’s return to work instead of thirty-one (31).

A new section entitled “Qualifying Event During a Period of Ineligibility” has been added at 111-4-1-.06(3). If the Employee loses eligibility and subsequently resumes eligibility for Coverage within the same Plan Year, and a Qualifying Event occurs during the period of ineligibility, the Employee may request a change in Coverage for the remainder of the Plan Year. The request must be made to the Administrator within thirty-one (31) days of resumed eligibility. The Administrator may request supporting documentation. Failure to supply supporting documentation may result in reversal of Coverage and restoration of the former Coverage election.

A new provision has been added at 111-4-1-.06(4) clarifying the Retired Employees may discontinue Coverage at any time by advance notice to the Administrator.

The number of days for an Employee who has been reinstated across Plan Years to enroll or change Coverage has been changed from thirty-one (31) days to fifteen (15) calendar days in the newly renumbered 111-4-1-.06(5)

The former 111-4-1-.06(4) entitled “Enrollment Other than Open Enrollment” has been deleted in its entirety.

The heading for the newly renumbered 111-4-1-.06(6) has been changed from “Coverage Changes Other than Open Enrollment or Retiree Option Change Period” to “Qualifying Life Event Coverage Changes.” The word “election” has been placed behind the word “Coverage” for clarification purposes. Wording has been added indicating that requests to “enroll” for Coverage must be “received by the Administrator” no later than thirty-one (31) “calendar” days following the Qualifying Event. The phrase “unless otherwise noted in the specific Provision” has been deleted as it is not necessary to convey the meaning of the sentence. The words “change or discontinuation” have been replaced with “Coverage election,” as the defined term Coverage captures the intended meaning. Language has been inserted to state that the Administrator may request supporting documentation to prove the Qualifying Event occurred, and that failure to submit the documentation within the specified time may result in reversal of the Coverage election.

The words “or decrease Coverage” have been inserted and the words “Tier” and “or change to single coverage” have been deleted in 111-4-1-.06(a) consistent with appropriate application of the new phraseology. The requirement that a request for change or discontinuance be filed no later than thirty-one (31) days following the Qualifying Event has been eliminated as a business requirement. A statement has been added stating that documentation of Coverage under the other Employer’s group health benefit plan may be required.

Additional language has been added at 111-4-1-.06(6)(b) clarifying that eligible Members may enroll themselves or their eligible Dependents for Coverage when Dependents are acquired through “legal guardianship.” The phrase “a change to ‘family’ Coverage Tier is permissible” has been deleted as it is no longer necessary to convey the meaning of the sentence. A cross-reference has been inserted referencing the Coverage effective dates for Dependent Coverage at 111-4-1-.05 of these regulations. Documentation for Dependent eligibility for Coverage may be required.

New wording has been added at the beginning of 111-4-1-.06(6)(c) stating that an Enrolled Member who loses membership under another group health benefit plan as a result of divorce, legal separation or death may change Coverage under the SHBP, which is reflective of the Plan’s policy. Additionally, existing language has been revised using the new terminology and stating that a Member may increase Coverage when an Active Employee, Employee’s Spouse or eligible Dependent loses or discontinues other group health benefit plan membership through other employment, Medicaid, or Medicare. Throughout this subsection, the word “former” replaces the word “ex,” as the word “former” may convey the meaning more clearly. Language has been revised indicating that documentation of the loss of group health benefit plan membership may be required.

In 111-4-1-.06(6)(d), the words “one of the following” have been placed in sentence one to create a numbering system (1)- (4) for the categories listed in that sentence, and the words “the loss of eligibility” appear immediately following the newly inserted number (4) for clarification purposes. Soon thereafter, the word “Covered” has been inserted in front of the word “Dependent” indicating the appropriate defined term for a Dependent with Coverage. (The insertion of the word “who” and the verb change to “meets” are merely grammatical as referenced generally in the beginning of this section’s synopsis). The sentence referring to changing from family to single Tier has been deleted, as it reflects the old terminology and business practices. As such, language has been revised indicating that the Administrator shall decrease the Member’s Tier or the Enrolled Member may request a decrease in Tier, as the use of the word “decrease” in Tier is consistent with the new phraseology. The words “Qualified Medical Child Support Order” appear in front of “QMCSO,” (which has been placed in a parenthetical) in order to clarify the meaning of the acronym. Once again, the word “Covered” is placed in front of the word “Dependent” indicating a Dependent who has Coverage. Finally, the words “the change” have been replaced by “decrease in Tier” clarifying which change is being referenced.

In 111-4-1-.06(6)(e), the phrase “of these regulations” has been inserted for clarification purposes. The phrase “enroll themselves and all eligible Dependents in Coverage or increase Tier” replaces the words “change from ‘single’ to ‘family’ Coverage Tier” as the word change reflects the use of the new terminology and phraseology. The thirty-one (31) calendar day requirement has been eliminated. Language has been added specifying that the effective date of Coverage shall be the first of the month following the request unless the Member elects to include the newborn from the date of birth, for which the effective date of Coverage shall be the first of the month of birth. Former language regarding collection of Premiums has been deleted and new language added stating that the appropriate Premiums for prior months of Coverage will be collected from the date that the Member elects the Coverage. Also, language has been revised referencing the eligibility and Coverage dates rules in 111-4-1-.04 and 111-4-1-.05 of the regulations. Finally, language has been added stating that Dependent eligibility may have to be verified.

In 111-4-1-.04(6)(f), “change to single” has been changed to “decrease” representative of the new phraseology. The word “Covered” appears in front of the word “Dependent” throughout the subsection indicating the defined term for a Dependent who has Coverage. Wording has been added clarifying that the removed Spouse or Dependents removed from the Member’s contract are covered under the other employer’s group health benefit plan. The thirty-one(31) day requirement for eligibility of another group health benefit plan’s coverage has been removed. Throughout the subsection, either the word “health” or “health benefit” have been added so that the words read consistently as “group health benefit plan.” Also, language has been added that the effective date of the change in Coverage shall be the later of the first of the month following receipt of the request or the date the Spouse or Dependent becomes covered under the other group “health” plan.

In 111-4-1-.06(6)(g), the word “eligible” has been placed in front of the term “Member” in more than one place in the section indicating eligibility. Language has been revised indicating that there shall be an “increase” in Coverage with, the submission of a valid QMCSO. The acronym “QMCSO” replaces the words “Qualified Medical Child Support Order” because the words for the acronym have been spelled out in a previous section. Throughout the provision, the former term “Coverage Tier” has been replaced with the new term “Tier” as it relates specifically to increase in Coverage. Language has been added stating that an Enrolled Member with a QMCSO will be allowed to change from an HMO Option to a Regular Insurance Option upon request subject to any timely filing requirements, consistent with Plan policy.

In 111-4-1-.06(6)(h), the word “eligible” is placed in front of the word “Employee” emphasizing eligibility. The words “increase” and “decrease” replace the reference to “change,” as those words reflect the new phraseology indicating a change in Tier. The word “calendar” has been inserted clarifying that the days shall be counted consecutively.

In 111-4-1-.06(6)(i), the word “Retired Subscriber” has been replaced with “enrolled Retirees,” as Subscriber has been eliminated as a defined term. The new phraseology referencing becoming individual Enrolled Members replaces the old phraseology discussing family to single Coverage Tier. The phrase “when no individuals other than the Spouse are enrollee in the Coverage,” is added for clarification purposes. The word “calendar” is inserted indicating two consecutive calendar months and the words “the Administrator’s notice of” is deleted as it is not necessary to convey the meaning of the sentence.

In 111-4-1-.06(j), the words “change to single” has been changed to the new phraseology “decrease” in Coverage. Throughout the subsection, the word “calendar” has been inserted in front of the word days clarifying that days within the subsection will mean consecutive calendar days. “Subscribers enrolled in single Tier” has been replaced with the new phraseology “Enrolled Members who have no Covered Dependents,” which makes use of the defined terms.

In 111-4-1-.06(6)(k), the language has been revised to reflect the new phraseology of “an increase” in Coverage Tier. Additionally the words “from a participating retirement system,” have been added to indicate from where the monthly benefit will be drawn.

In 111-4-1-.06(l), the language has been revised to reflect the new phraseology of having a “decrease” Tier. The alleviated term “Subscriber’s” has been changed to the appropriate term “Employee’s.” The word “coverage” has been changed to “enrollment status,” reflecting that the enrollment status changed. The words “a non-participating,” “health,” and “employer’s” have been inserted clarifying another employer’s health plan. The word “health” has been inserted in front of the word “benefit” and the word “group” has been inserted in front of the word “health” for clarification purposes. The words “enrollment, change, or discontinuation” have been deleted and replaced with the more succinct “Coverage action.” Finally, language has been added stating that the Administrator may require documentation to substantiate the Spouse’s Open Enrollment election meets the criteria of the paragraph at hand.

The former 111-4-1-.06(6) has been deleted as it is not necessary for current Plan operations.

In the newly renumbered 111-4-1-.06(m), wording has been revised making proper use of defined terms stating when an Enrolled Member may elect an Option when the Enrolled Member changes residency and is no longer a part of a Managed Care Plan’s network of providers as contracted for with the SHBP.

In 111-4-1-.06(m)(1), unnecessary wording has been deleted and a sentence has been added stating that the Enrolled Member may change Option when a change in residency occurs that places the Enrolled Member’s residence outside of the Managed Care Plan’s network. The wording in number 2 that immediately follow this subsection

has been eliminated inasmuch as it is not necessary to convey the business operation of the Plan.

In 111-4-1-.06(m)(2), the new name “Medicare Advantage” takes the place of the former name Medicare + Choice managed care. The word “Employee’s” has been eliminated where it is not necessary to convey the meaning of the sentence. The defined term “Coverage” has been inserted where necessary. The word “Basic” has been eliminated as it no longer describes a PPO Option. The words “an Option designated by the Administrator” have been inserted to indicate the Option(s) the Plan may make available to an Enrolled Member who loses access (through a change in residency) to his or her Managed Care Plan’s network under the SHBP. The word “occurrence” has been deleted and replaced with “Qualifying Event,” more specifically referencing what an occurrence would be.

In 111-4-1-.06(m)(3), the new name “Medicare Advantage” takes the place of the former name Medicare + Choice. The word “Basic” has been eliminated as it no longer describes a PPO Option. The words “or other designated” have been inserted to indicate Options other than the PPO. The word “occurrence” has been deleted and replaced with “Qualifying Event,” more specifically referencing what an occurrence would be.

In 111-4-1-.06(n), either the words “an enrolled Retiree” or “Retiree” replace the eliminated term “Subscriber.” The words “selection form is filed with” has been replaced by the words “the request is received by” for more clear wording. The reference to days has been clarified as “calendar” days to suggest consecutive days. The word “Qualifying” has been inserted indicating a “Qualifying Event.”

The word “participating” has been added to 111-4-1-.06(n)(2) to clarify that the retirement system must be a participating one.

The former sections covering “Option Changes at the Loss of Other Coverage,” “Qualified Medical Child Support Order (QMCSO),” “Option Changes at Change of Residence,” and “Discontinuance of Coverage”) ((c), (d), (e), and the number (7) respectively) have all been deleted as not necessary to the business operation.

At 111-4-1-.06(7), a new section has been added stating that the Administrator may require documentation of a Qualifying Event. Failure to supply the documentation within the appropriate time period will result in reversal of the requested Coverage action and restoration of the Member’s prior Coverage.

The words “Internal Revenue Code” have been spelled out replacing the reference to the “Treasury Regulation.”

111-4-1-.07 Extended Coverage Under State Law.

(1) **Employee.** Employees are permitted to continue the current Coverage ~~Tier and Option~~ under conditions outlined by State Law. Application for Extended Coverage must be made to the Administrator within thirty-one (31) calendar ~~sixty (60)~~ days following Coverage termination as an Active Employee or Extended Beneficiary. Coverage election under Section 111-4-1-.08, Extended Coverage Under Federal law, delays eligibility to enroll under State Law provisions until the expiration of the Extended Beneficiary Coverage privileges, except as specifically stated in these provisions.

(a) **State Employee.**

1. Any State Employee who resigns from employment or who is not re-elected on and after July 1, 1978 and who has completed eight (8) or more years of service as an Employee, exclusive of Approved Leaves of Absence Without Pay for which health benefit Coverage may have been continued, ~~as an Employee~~ under Section 111-4-1-.04(1)(a) shall have the privilege of continuing Coverage.

2. Any State Employee who has been eligible for Coverage under this Plan for a period of ten (10) years, is discharged and is appealing the discharge to the State Personnel Board shall be entitled to continue Coverage for a period required for the State Personnel Board to render a decision but no longer than six (6) calendar months. The Premium for such Coverage will be the same amount as paid by the Active Employee through payroll Deduction/Reduction. The Employing Entity must notify the MemberSubscriber and the Administrator of the Member'sSubscriber's eligibility to continue Coverage. Failure to pay the full Premium within the allotted time shall result in suspension of benefit payments and/or termination of Coverage and forfeit all eligibility for continued Coverage.

(b) **General Assembly Member.** Any member of the General Assembly who ceases to hold office after July 1, 1981, and who was eligible to retire at the time of leaving office, except for the attainment of retirement age, pursuant to a public retirement system to which the General Assembly appropriates Funds, and who does not withdraw Employee contributions from public retirement systems shall be eligible to continue Coverage for the Enrolled MemberSubscriber and eligible Dependents, subject to the conditions of these regulations. The Premium shall be the same amount as an Active Employee. Coverage shall cease if the MemberSubscriber fails to pay the required Premium billed by the Administrator within thirty (30) calendar days following receipt of a Premium notice or the MemberSubscriber withdraws Employee contributions from the respective retirement system. Failure to pay the full Premium within the allotted time shall result in suspension of benefit payments and/or termination of coverage and forfeit all eligibility for continued Coverage.

(c) **Teacher.** Any Teacher as defined in Section 111-4-1-.04(1)(b) and any Surviving Spouse of a Teacher who died prior to January 1, 1979 who has eight (8) or more years of creditable service in a teachers retirement system in Georgia and who is not presently eligible to receive retirement benefits shall have the privilege of continuing Coverage.

(d) **Public School Employee.** Any ~~P~~ublic ~~S~~chool Employee as defined in Section 111-4-1-.04(1)(c) and who has eight (8) or more years of creditable service in a retirement system in Georgia and who is not eligible to receive retirement benefits because of age shall have the privilege of continuing ~~C~~eoverage. Prior to December 1, 1986, a ~~P~~ublic ~~S~~chool Employee whose employment terminated after January 1, 1985, and prior to July 1, 1986, under these conditions shall have the privilege of re-enrolling for ~~C~~eoverage by making application to the Administrator; provided that ~~C~~eoverage shall not become effective earlier than the first of the month in which the application for ~~C~~eoverage was received by the Administrator.

1. **Correctional Officers Injured in Service.** The SHBP shall provide a ~~C~~eoverage exception from the eight-year or more employment requirement for continued ~~C~~eoverage under the SHBP for a correctional officer injured by inmate violence while on duty if the correctional officer demonstrates that he or she was injured within a time period of five (5) years or less from becoming eligible for Medicare. The correctional officer must remit the Premium amount established for Active Employees. Eligibility for ~~C~~eoverage shall extend to an eligible correctional officer's Spouse or Dependents.

(e) **Required Premiums.** Except as noted in subparagraphs (a)(2) and (b), premiums for continuing ~~C~~eoverage under this provision shall be billed to the ~~Enrolled MemberSubscriber~~ monthly in an amount equal to the total cost for ~~C~~eoverage, which is the Employee's share and the ~~E~~mployer's cost for benefits and administration, plus processing and administrative fees where applicable. Failure to pay the ~~full P~~remium within the allotted time shall ~~result in suspension of benefit payments and/or termination of Coverage and~~ forfeit ~~all~~ eligibility for continued ~~e~~overage.

(f) **Notice.** The Administrator shall include a notice of payment requirements and penalties on application forms for continued ~~C~~eoverages.

(2) **Pending Retiree.** An ~~Enrolled Memberactive-Employee~~ who has made application for disability or service retirement and who may be eligible for retirement shall have the privilege of continuing any health benefit ~~C~~eoverage during the period between termination of ~~C~~eoverage as an ~~A~~ctive Employee and the effective date of ~~C~~eoverage as a Retiree, subject to conditions as outlined in these regulations. ~~Application to continue coverage must be filed with the Administrator within sixty (60) days following coverage termination as an active Employee. The Member may request Coverage as a Pending Retiree within thirty-one (31) calendar days following Coverage termination as an Active Employee. The Administrator shall have the option to enroll and bill the Member directly for Pending Retiree Coverage should a break in Coverage occur.~~

(a) **Coverage as a pending Retiree** must be based on a reasonable expectation that the ~~Enrolled Memberactive-Employee~~ is eligible for retirement except for completion of the administrative processing to begin the annuity payments. The Administrator may define reasonable expectation; however, continuation of coverage under this provision shall not exceed six (6) ~~calendar~~ months, unless a decision on the retirement application has not been rendered by the respective retirement system's administrative processes. Any months of coverage as a ~~P~~ending Retiree shall be inclusive of Extended Coverage ~~provisions~~ under Federal law.

(b) **Denial of Annuity Payments.** At the point that a Board of trustees or retirement Administrator denies the immediate onset of annuity payments, the separated Employee shall no longer be eligible to continue ~~C~~coverage under this provision. Any ~~C~~coverage under this provision is inclusive of the maximum length of time allowed under the Extended ~~CoverageBeneficiary~~ provisions that are allowed under Federal law.

(c) **Reinstatement of Retiree Coverage.** Upon receipt of information that the respective retirement system has reversed an earlier denial to award retirement benefits to an Employee, ~~C~~coverage may be reinstated as a Retiree. Coverage reinstatement is allowed if the Retiree requests reinstatement within ~~thirty-one (31) calendrsixty (60)~~ days following the reversal of the retirement system's decision. Reinstatement shall be effective as soon as administrative processes for ~~D~~eduction are completed, but no later than sixty (60) ~~calendar~~ days following notification to the Administrator. The Retiree and ~~D~~ependents who were enrolled in the Plan will be reinstated without regard to the ~~P~~re-existing ~~C~~ondition limitations. The Administrator may review the circumstances and, if undue hardship will be imposed upon the Retiree, may allow retroactive coverage for up to six (6) ~~calendar~~ months from the date of notification that the Retiree is eligible for reinstatement.

(d) **Required Premiums.** Premiums for continuing coverage under this provision shall be the same as the Employee ~~D~~eduction ~~R~~ate plus a processing fee and shall be paid monthly. Failure to pay the full Premium within the allotted time shall result in suspension of benefit payments and/or termination of Coverage and forfeit all eligibility for continued Coverage.

(3) **Retiree Retirement Benefit.** If the retirement benefit to be received by a Retiree of any one of the respective retirement systems is not sufficient to pay the ~~P~~remium amount by ~~annuitypayroll D~~eduction, the Retiree shall be permitted to continue ~~C~~coverage by paying a ~~monthlyquarterly P~~remium as set by the Board directly to the Plan. The ~~P~~remium ~~R~~ate shall be the same as the Retiree ~~D~~eduction ~~R~~ate plus a processing fee. Failure to pay the full Premium within the allotted time shall result in suspension of benefit payments and/or termination of Coverage and forfeit all eligibility for continued Coverage.

Authority O.C.G.A. Secs. 20-2-888, 20-2-915, 20-2-915.1, 45-18-1 et seq. **History.** Original Rule entitled "Extended Coverage Under State ~~L~~aw" adopted. F. Apr. 18, 2005; eff. May 8, 2005.

PROPOSED RULE
OF THE
GEORGIA DEPARTMENT OF COMMUNITY HEALTH
RULE 111-4-1-.07

STATEMENT OF PURPOSE AND MAIN FEATURES OF PROPOSED RULE:

The purpose of this proposed rule is to make the rules and regulations consistent with anticipated business operation changes.

DIFFERENCES BETWEEN EXISTING RULE AND PROPOSED RULE:

Errors in capitalization have been corrected.

Throughout this subsection, the appropriate forms (singular, plural, or possessive) of the newly defined terms “Member,” or “Enrolled Member” replace the words “Employee” or “Subscriber,” as necessary and appropriate.

In 111-4-1-.07(1), the words “the current” are inserted for clarification purposes. The time period for submission requirements has been changed from sixty (60) days to thirty-one (31) days. The phrase “in these provisions” has been inserted to emphasize the intent.

In 111-4-1-.07(1)(a)(1), the words “as an employee” have been deleted as it is not necessary to convey the intended meaning of the provision.

In 111-4-1-.07(1)(a)(2), the word “calendar” has been inserted to clarify that the time period specified will be consecutive calendar months. The word “full” has been inserted in front of the word Premium to clarify that the entire Premium amount must be paid. And, additional language has been inserted stating that failure to submit the full Premium will result in termination of Coverage for “all” continued Coverage.

In 111-4-1-.07(1)(b), the word “full” has been inserted in front of the word “Premium” to make clear that the entire Premium amount must be paid. Also, language has been added stating that failure to submit the full Premium might result in suspension of benefit payment or termination of Coverage.

In 111-4-1-.07(1)(e), The word “full” has been inserted in front of the word Premium to clarify that the entire Premium amount must be paid. And, additional language has been inserted stating that failure to submit the full Premium will result in termination of Coverage for “all” continued Coverage.

In 111-4-1-.07(2), language has been revised to indicate that a Member may request Coverage as a Pending Retiree within thirty-one (31) calendar days following Coverage termination as an Active Employee as opposed to sixty (60) days. Language has also been added allowing the Administrator the option of enrolling and billing the Member directly for Pending Retiree Coverage should a break in Coverage occur.

The word “calendar” has been inserted into 111-4-1-.07(2)(a) to indicate that the months shall be counted as consecutive calendar months. Also, the word “provisions” has been inserted to make the meaning more clear.

In 111-4-1-.07(2)(b) the word “Beneficiary” has been replaced with the word “Coverage” as the newly defined term more appropriately captures the intended meaning of the provision. The word “provisions” has been inserted for clarification purposes.

In 111-4-1-.07(c), the first reference to sixty (60) calendar days has been changed to thirty-one (31) calendar days shortening the time period. The word “calendar” has been inserted in front of the subsequent references to days or months for clarification purposes.

A statement has been added to 111-4-1-.07(2)(d) stating that failure to remit the full Premium within the allotted time may result in suspension of benefit payments or termination of Coverage, forfeiting eligibility for continued Coverage.

In 111-4-1-.07(3), the word “payroll” has been replaced with “annuity,” referring more appropriately to a Retiree Deduction. Instead, of quarterly, Deductions will be made monthly and the Premium payments will be made “directly to the Plan.” Language has been added stating that failure to pay the full Premium within the allotted time shall result in suspension of benefit payments and/or termination of Coverage and forfeit of eligibility for continued Coverage.

111-4-1-.08 Extended Coverage Under Federal Law (COBRA).

(1) **Extended Beneficiary.** Persons who lose coverage under the Plan and who meet requirements as specified in these regulations or as specified by federal law are eligible to continue Ce coverage in the enrolled Option, without evidence of insurability. An Extended Beneficiary shall have the same opportunities for enrolling eligible De dependents and changing Coverage election Tiers and Options as Aactive Employees. The SHBP will be administered in compliance with federal law or regulation under the Consolidated Omnibus Budget Reconciliation Act (COBRA).

(a) **Terminated Employee.** An enrolled Employee who terminates employment or is separated from his employment for any reason other than for gross misconduct, or whose Approved Leave Without Pay Coverage period expires shall be eligible to continue Ce coverage under the Plan for a period not longer than eighteen (18) calendar months following the termination of Ce coverage as an Employee.

(b) **Reduction of Required Hours.** An enrolled Employee who continues SHBP eligibility under the definition of Employee, except for working the required number of hours, shall be eligible to continue Ce coverage under the Plan for a period not longer than eighteen (18) calendar months following the end of the month in which the reduction of hours occurred. If the reduced hours take effect on a day other than the first work day of the month, the eighteen (18) calendar month period would begin on the first of the month following termination of Ce coverage through payroll De deductions.

(c) **Laid-off Employee.** An Enrolled Employee who is determined to be a laid-off Employee shall be eligible to continue Ce coverage under the Plan for a period not longer than eighteen (18) months. The extended period begins on the first of the month following termination of Ce coverage through payroll De deductions.

(d) **Spouse of Deceased Employee.** The spouse of a deceased enrolled Employee who is not eligible as a Surviving Spouse, an Employee, or an Annuitant shall be eligible to continue Ce coverage for the Spouse and any Ce covered, eligible dependents under the Plan for a period not longer than thirty-six (36) calendar months. The extended period of Ce coverage begins on the first of the month following termination of Ce coverage through the deceased Employee's payroll De deductions, or if the Employee is on an Approved Leave Without Pay, the later of the end of the month or the end of one month following the month in which the Employee died when Premium was paid in advance.

(e) **Surviving Dependent Child.** An eligible De dependent child of a deceased enrolled Employee who is not eligible as a De dependent of another Employee, a Surviving Beneficiary under Section 111-4-1-.04 (10), and Employee, or an Annuitant shall be eligible to continue individual Ce coverage under the Plan for a period not longer than thirty-six (36) calendar months following the end of the month in which death occurred. Any months for which Ce coverage was granted under Section 111-4-1-.04(10) will be included in the maximum allowance under this provision. The Extended Coverage period begins on the first of the month following termination of the deceased Employee's Ce coverage through payroll De deductions.

(f) **Dependent Child.** An eligible Dependent child of an enrolled Employee who is not eligible as an Employee or an Annuitant shall be eligible to continue Coverage under the Plan for a period not longer than thirty-six (36) calendar months following the end of the month in which the child is no longer an eligible Dependent under the Plan.

(g) **Legally Separated or Divorced Spouse.** A legally separated or divorced Spouse of an enrolled Employee who is not eligible as a Surviving Spouse, an Employee, or an Annuitant shall be eligible to continue Coverage for a period not longer than thirty-six (36) calendar months for the Spouse and any enrolled-eligible Covered dependents, who are no longer Covered Dependents of the Employee, under the SHBP. The Extended Coverage period begins on the first of the month following the month in which the legal separation documents were approved by a court of competent jurisdiction or the divorce was final.

(h) **Disability under Social Security.** An additional eleven (11) calendar months of Coverage may be provided to an Extended Beneficiary who meets the definition of disability under Title II or XVI of the Social Security Act prior to or within sixty (60) calendar days of the Qualifying Event. The eleven (11) additional months of Coverage applies to all Beneficiaries eligible under the contract. Eligibility for the additional eleven (11) months is based on the Beneficiary notifying the Administrator of the determination of disability no later than sixty (60) calendar days following the date of the determination. Such notices must be given within the initial eighteen (18) month continuation period. Additionally, the Extended Beneficiary must notify the Administrator within thirty (30) calendar days of the date of any final determination that the Beneficiary is no longer disabled. The Administrator is authorized to charge one hundred fifty percent (150%) of the applicable Premium as outlined ~~under Section 111-4-1-.08(1)~~ in this section.

(i) **Multiple qualifying events.** If additional Qualifying Events occur which provide for a thirty-six (36) calendar month maximum period during the period when an Extended Beneficiary is covered, the maximum period of Coverage may be extended to a maximum of thirty-six (36) calendar months for Spouse or Dependent Child.

(j) **Beginning of the maximum period.** The maximum period of Extended Coverage as a result of one or more Qualifying Events shall begin on the day following termination of Coverage as a result of the first Qualifying Event.

(k) **Limitation for Individuals Added to Coverage of Extended Beneficiary.** Individuals enrolled under an Extended Beneficiary's Coverage shall not be eligible to become an Extended Beneficiary as a result of the enrollment.

(l) **Payment for Extended Beneficiary Coverages.** The applicable Premium for any Coverage ~~election~~Option shall include the total Employer and Employee cost plus two percent (2%) of the total Premium cost as established by the Board for Active Employees with eligibility under ~~this s~~Section 111-4-1-.08(1), except that the Extended Beneficiary shall pay this Premium on a monthly basis. An additional forty eight percent (48%) of the total Premium ~~cost~~ for the Coverage ~~election~~Option under the Plan shall be required for the eleven (11) months extension as a result of disability under the Social Security Act. One (1) advance monthly premium plus any retroactive premiums

for unpaid periods of Coverage will, however, be requested as a part of the application. Failure to pay the full Premium within the allotted time shall result in suspension of benefit payments and/or termination of Coverage and forfeit all eligibility for continued Coverage.

(m) **Notice Requirements.** At the time of implementation of the Extended Beneficiary provisions, the Administrator shall distribute to the Employing Entities, having Aactive Employees, a notice of reasons for the extended eligibility. The Employing Entities shall distribute this notice to each eligible Employee. The Administrator shall incorporate the Extended Beneficiary eligibility provisions in the Employee Summary Plan Description.

1. The Employing Entity must notify the Administrator of the Employee's termination, death, layoff, or reduce hours within thirty (30) calendar days following the event.

2. The Subscriber/enrolled Employee or eligible Beneficiary must notify the Administrator of a Qualifying Event in case of divorce, legal separation, or the Dependent child's loss of eligibility within sixty (60) calendar days of the later of the Qualifying Event or termination of Coverage as a result of the Qualifying Event. Failure to notify the Administrator within the sixty (60) calendar days will forfeit eligibility to enroll as an Extended Beneficiary.

3. The Administrator shall notify the Extended Beneficiary at the known address. The Administrator shall provide notice of the continuation rights within fourteen (14) calendar days following notification from the Employing Entity of the enrolled Employee's death, termination of employment, or reduction of hours. Notice to the Employee's Sspouse other than upon the Employee's termination or reduction of hours shall be deemed to be notification to all other Beneficiaries under the contract.

4. The Administrator shall notify the Extended Beneficiary of the continuation rights at the address specified by the Employee or Extended Beneficiary within fourteen (14) calendar days following notification from the Employee of a divorce, legal separation, or the Dependent child's Coverage ineligibility as a Dependent.

5. The Administrator shall notify each newly covered Spouse of the Plans Extended Beneficiary continuation rights within fourteen (14) calendar days of the Spouse's effective date.

65. If the Administrator fails to notify the Extended Beneficiary of the continuation rights within the required time limits as a result of failure of the Employing Entity to notify the Administrator, any penalty required of the Administrator shall be billed to the Employing Entity who failed to notify the Administrator.

(n) **Extended Beneficiary's Election Period.** The Extended Beneficiary may elect to continue Coverage during the later of sixty (60)calendar days following the Administrator's notification to the Extended Beneficiary or the sixty (60) calendar days following Coverage termination. Coverage will be continued from the Coverage termination date through the months for which payment is received, provided payment is

received no later than forty-five (45) calendar days following the Beneficiary's election to continue Coverage.

(o) **Extended Beneficiary's Independent Election.** Each Beneficiary eligible for Extended Coverage shall be afforded the opportunity to make an independent election to continue Coverage in the enrolled Option, provided the Beneficiary is not enrolled under the SHBP as an Employee, Sspouse, Dependent, or Annuitant. If a Beneficiary, either the Employee or Sspouse of a ~~covered/enrolled~~ Employee makes an election to provide Coverage for the other Extended Beneficiary, the election shall be binding on that other Beneficiary. An election on behalf of a minor child can be made by the child's parent or legal guardian. An election on behalf of an eligible Beneficiary who is incapacitated can be made by the legal representative of the Beneficiary. Except for any child who is born to or placed with an Extended Beneficiary, Dependents enrolled in the Plan during a period of Extended Coverage under federal law do not themselves become Extended Beneficiaries and may not make separate Coverage elections or participate in Open Enrollment.

(p) **Required Documentation.** The Administrator may require a monthly certification on the Premium billing by the Extended Beneficiary that the conditions as outlined in Section 111-4-1-.09(11) have not occurred.

(q) **Recovery of Paid Benefits.** The Administrator shall have the right to recover all benefit payments made on behalf of any Extended Beneficiary as a result of and after the occurrence of any of the conditions outlined in Section 111-4-1-.09(11).

~~(2) **Conversion.** The Administrator may provide an arrangement for offering the member, who no longer has eligibility to continue coverage under the SHBP, an Option to convert health coverage to an individual policy. If the member is enrolled in a regular insurance Option at the time his coverage terminates, the individual policy shall be with an insurance carrier and shall be under the terms and conditions of the underwriter for such policy. If the member is enrolled in an HMO Option at the time his coverage terminates, and the Plan's contract with the HMO provides for a conversion policy option, the individual policy shall be with the HMO or an insurance carrier arranged by the HMO and shall be under the terms and conditions of the HMO or underwriter. The privilege to convert to the individual policy shall be permitted at the beginning of any month within one hundred eighty (180) days prior to the termination of the individual's maximum extended coverage period, provided the application is made a minimum of thirty (30) days before the requested effective date of the individual policy. If the employee or covered dependent is not eligible to participate in the Extended Coverage under federal law, an application to the TPA must be filed no later than thirty (30) days following termination of coverage under the Plan.~~

Authority U.S. Internal Revenue Code and Consolidated Omnibus Budget Reconciliation Act (COBRA). **History.** Original Rule entitled "Extended Coverage Under Federal Law (COBRA)" adopted. F. Apr. 18, 2005; eff. May 8, 2005.

PROPOSED RULE
OF THE
GEORGIA DEPARTMENT OF COMMUNITY HEALTH
RULE 111-4-1-.08

STATEMENT OF PURPOSE AND MAIN FEATURES OF PROPOSED RULE:

The purpose of this proposed rule is to make the rules and regulations consistent with anticipated business operation changes.

DIFFERENCES BETWEEN EXISTING RULE AND PROPOSED RULE:

Errors in capitalization have been corrected.

Throughout this subsection, the appropriate forms (singular, plural, or possessive) of the newly defined terms “Member,” or “Enrolled Member” replaces the words “Employee” or “Subscriber,” as necessary and appropriate.

The word “enrolled” has been inserted in front of the term “Employee” in several places throughout the section indicating that the Employee being referenced has enrolled in the Plan.

The word “calendar” has been placed in front of the words month(s) or day(s) in several places throughout the section clarifying that the time period will be either consecutive calendar months or days as appropriate.

The word “election” now follows the defined term “Coverage” in 111-4-1-.08(1) indicating that an election for Coverage has been made, and the words “Tiers and Options” have been deleted inasmuch as they are no longer a part of the defined term “Coverage.”

In 111-4-1-.08(1)(a), the word “period” has been placed behind the word “Coverage” indicating the period of time for Coverage.

In 111-4-1-.08(1)(e), the (10) has been deleted in 111-4-1-.04(10) such that only the necessary reference to 111-4-1-.04 remains.

In 111-4-1-.08(1)(g), the words “enrolled eligible” have been deleted immediately preceding the word “Dependent” and the word “Covered” has been inserted in its place such that the defined term “Covered Dependent” is used.

In 111-4-1-.08(1)(h), the words “in this section” replace the words “under Section 111-4-1-.08(1) as the new reference encompasses the entire section.

In 111-4-1-.08(1)(l), the words “Coverage election” replace the deleted word “Option” indicating an election has been made for Coverage. The defined term “Active” has been placed in front of the word “Employees” indicating a current Employee. The specific reference to 111-4-1-.08(1) has been deleted and a general reference has been made to the section by placing the word “this” in front of the word “section.” The word “cost” has been deleted from behind the defined term “Premium” as it is not necessary to convey the term’s meaning. Once again, the words “Coverage election” replace the deleted word “Option” indicating an election has been made for Coverage. Finally, a statement has been added providing adequate notice that failure to pay the full Premium within the allotted term will result in suspension of benefit payments and/or termination of Coverage and forfeiture of eligibility for continued Coverage.

Wording has been added at 111-4-1-.08(1)(m)(5) stating that the Administrator shall notify each newly covered Spouse of the Plan’s Extended Beneficiary continuation rights within fourteen (14) calendar days of the Spouse’s effective date.

The section on conversion has been deleted at 111-4-1-.08(2) as it will not be an option.

111-4-1-.09 Termination of Coverage.

(1) **Termination from Employment.** Termination from employment includes resignation, abandonment of job, release from job, forfeiture of job, and all other types of termination. Health benefit Coverage shall terminate at the end of the month following the month of the last deduction date of employment that was transmitted to the Administrator unless continued under the provision of Extended Coverage. This date will normally be the end of the month following the month in which separation or termination of employment occurred.

(2) **Employment Layoff.** Employment layoff means that the Employer has formalized a reduction in staff plan and the Employee will no longer be employed by one of the Employing Entities. Health Benefit Coverage shall terminate at the end of the month following the month of the last date of employment deduction that was transmitted to the Administrator, unless continued under the provisions of Extended Coverage. The Coverage termination date will normally be the end of the month following the month in which the layoff occurred.

(3) **Reduction of Hours.** A reduction in hours worked may result in loss of eligibility to continue health benefit Coverage.

(a) If for any reason the number of worked hours is reduced for a covered State Employee to less than thirty (30) hours per week, Coverage shall terminate at the end of the month following the month in which the reduced hours took effect; unless continued under the provisions of Extended Coverage.

(b) If for any reason the number of worked hours is reduced for a covered Teacher to less than half-time or a minimum of seventeen and one-half (17 ½) hours per week, Coverage shall terminate at the end of the month following the month in which the reduced hours took effect; unless continued under the provisions of Extended Coverage.

(c) If for any reason the number of worked hours is reduced for a covered Public School Employee to less than sixty (60) percent of that required to perform the position duties, Coverage shall terminate at the end of the month following the month in which the reduced hours took effect; unless continued under the provisions of Extended Coverage. However, the sixty (60) percent cannot be less than twenty (20) hours if the Member is a participant in the Teachers Retirement System and less than fifteen (15) hours if the member is a participant in the Public School Employees Retirement System.

(4) **Failure to Return from an Approved Leave of Absence Without Pay.** If an Subscriber Employee on an Approved Lease of Absence Without Pay fails to return to Active employment, Coverage will terminate at the earlier of the end of the month for which the Lease Without Pay was approved or the end of the month for which a valid Premium payment has been received. Failure to return to Active employment from an Approved Lease of Absence Without Pay will be considered termination of employment for the purposes of Extended Coverage eligibility.

(5) **Legal Separation or Divorce.** Coverage for a legally separated or divorced Spouse will terminate at the end of the month in which the separation papers were

approved by a court of competent jurisdiction or in which the divorce decree is approved by the court of competent jurisdiction unless continued as an Extended Beneficiary.

(6) **Dependent Child.** Coverage for an eligible ~~D~~ependent child shall terminate at the end of the month in which the child marries, enters into full-time military service, reaches age nineteen (19) unless a Qualified Medical Child Support Order (QMCSO) or other court order bears an earlier expiration date or ~~C~~eoverage is continued under the provisions for a Totally Disabled Child, an Extended Beneficiary, or as a Full-time Student.

(7) **Full-time Student.** Coverage as a ~~F~~ull-time ~~S~~tudent shall terminate at the earlier of the end of the month in which ~~the Administrator has determined the Dependent does not meet the criteria for Coverage~~~~the dependent child graduates~~, or

~~(a) At the end of the month in which the Dependent child graduates, or~~

~~(b)~~ At the end of the month in which academic requirements for graduation are completed if graduation is delayed more than one month, or

~~(c)~~ At the end of the month in which the child ceases to be in ~~F~~ull-time ~~A~~ttendance at an accredited school ~~unless the child's non-attendance follows attendance for three (3) successive quarters with intent to return during the fifth quarter, or two (2) successive semesters with intent to return during the fourth semester~~. The Administrator may cancel any certified period of ~~e~~overage on a prospective basis when information becomes available that the child no longer fulfills the requirements of a ~~F~~ull-time ~~S~~tudent.

(8) **Failure to Remit Premium.** Failure to remit the billed ~~P~~remium amount in full within thirty (30) calendar days following the end of the month for which ~~C~~eoverage has been paid will result in suspension of benefit payments and will constitute forfeiture of eligibility to continue ~~C~~eoverage while on Approved Leave of Absence Without ~~P~~ay or Extended Coverages of any kind. Coverage will not be reinstated for payments received thirty (30) calendar days following termination of ~~C~~eoverage for insufficient payment, unless an administrative error has been made. Failure to remit ~~P~~remium will constitute a declination of eligibility to continue coverage as an Extended Beneficiary without further notice by the Administrator.

(9) **Expiration of Approval Leave of Absence Without Pay.** Coverage will terminate at the end of the month following expiration of the Approved Lease of Absence Without Pay period unless the leave is extended by the appropriate organizational official and such extension is approved by the Administrator or the Employee returns to work, or the Employee extends coverage under the provisions of Extended Coverage. Coverage may be terminated earlier than the expiration of such leave when the Failure to Remit Premium provisions of these regulations apply.

(10) **Expiration of Coverage as a Pending Retiree.** Health benefit ~~C~~eoverage will terminate at the end of the month following determination that the ~~Subscriber~~Retiree is not immediately eligible to receive an annuity under a state supported participating retirement system operated for Employees, unless the ~~Subscribe~~Retiree is eligible to continue ~~C~~eoverage under the Extended Coverage provisions of these regulations.

Pending Retirees appealing a denial of retirement benefits may continue up to the maximum period outlined in Section 111-4-1-.07~~(4)~~.

(11) **Expiration of Extended Beneficiary Coverage Privileges.** Health benefit ~~C~~coverage for Extended Beneficiaries will terminate at the end of the month in which the earliest of the following conditions occur:

(a) The ~~full~~ ~~P~~premium ~~amount~~ is not paid within the time allowed under these regulations;

(b) The maximum ~~C~~coverage period permitted under these regulations is exhausted;

(c) The Extended Beneficiary becomes enrolled in Medicare benefits;

(d) The Extended Beneficiary becomes covered under another group health care plan by reason of employment or marriage, and pre-existing condition exclusions are not applied under the new coverage;

(e) Cancellation of contract with an organization with whom the Board of Community Health is authorized to contract;

(f) The State Health Benefit Plan is terminated.

(12) **Deceased ~~Subscriber~~Enrolled Member.** Coverage shall terminate no later than the end of the month of death of a ~~Subscriber~~Member enrolled in ~~single-Tier~~employee only ~~C~~coverage. Coverage shall terminate no later than the end of the month following the month of death of a ~~Subscriber~~Member enrolled in family-Tier ~~when the Coverage includes Dependents~~. The Employing Entity, retirement system or deceased's estate shall remit the appropriate ~~P~~premium. A surviving ~~B~~beneficiary may continue coverage as outlined in 111-4-1-.04~~(11)~~, the Extended Coverage provisions of these regulations.

(13) **Discontinuation of Coverage Outside Open Enrollment.** Coverage shall terminate no earlier than the end of the month following receipt of the request to discontinue ~~C~~coverage outside the annual Open Enrollment period. ~~Documentation of other Ccoverage may be required.~~ Requests to discontinue ~~C~~coverage must be approved by the Administrator. The Administrator may require documentation of other Coverage. may be required.

(14) **Suspension of Benefits ~~D~~ue to Nonpayment.** If an Employing Entity fails to ~~submit~~remit ~~P~~premiums or documentation or fails to reconcile bills in ~~the a proper and timely~~ manner required by the Plan, the Plan may suspend benefit payments for Enrolled Members of the Employing Entity.

Authority O.C.G.A. Secs. 20-2-881, 20-2-911, 45-18-1 et seq., IRS Code Section 125. **History.** Original Rule entitled "Termination of Coverage" adopted. F. Apr. 18, 2005; eff. May 8, 2005.

PROPOSED RULE
OF THE
GEORGIA DEPARTMENT OF COMMUNITY HEALTH
RULE 111-4-1-.09

STATEMENT OF PURPOSE AND MAIN FEATURES OF PROPOSED RULE:

The purpose of this proposed rule is to make the rules and regulations consistent with anticipated business operation changes.

DIFFERENCES BETWEEN EXISTING RULE AND PROPOSED RULE:

Errors in capitalization have been made.

Throughout this subsection, the appropriate forms (singular, plural, or possessive) of the newly defined terms “Member,” or “Enrolled Member” replaces the words “Employee” or “Subscriber,” as necessary and appropriate.

The word “calendar” has been placed in front of the word day(s) throughout the section clarifying that the time period will be consecutive calendar days.

In 111-4-1-.09(1), the word “deduction” has been deleted and replaced with the words “date of employment” indicating that Coverage will terminate at the end of the month following the date of employment provided to the Plan.

In 111-4-1-.09(2), the word “deduction” has been deleted and replaced with the words “date of employment” indicating that Coverage will terminate at the end of the month following the date of employment provided to the Plan.

Wording has been added to the end of 111-4-1-.09(3)(a) clarifying that Coverage termination will occur unless the Employee elects Extended Coverage.

Wording has been added to the end of 111-4-1-.09(3)(b) clarifying that Coverage termination will occur unless the Employee elects Extended Coverage.

Wording has been added to the end of 111-4-1-.09(3)(c) clarifying that Coverage termination will occur unless the Employee elects Extended Coverage. Also, a reference to twenty (20) hours has been inserted indicating that a Public School Employee participating in the Teacher’s Retirement System (TRS) cannot drop below twenty (20) hours and continue Coverage unless under the provisions of Extended Coverage.

The words “of Absence” have been inserted in the heading for 111-4-1-.09(4) so that the complete commonly used phrase “Leave of Absence Without Pay” appears together.

Wording has been added to 111-4-1-.09(7) indicating that Coverage for a full-time student will end once the Administrator determines that the Dependent no longer meets the criteria for Coverage. The reference to once the “Dependent child graduates” has been deleted and placed instead at 111-4-1-.09(7)(a), stating that once the month in which the Dependent child graduates ends, Coverage will also end.

In 111-4-1-.09(7)(c), the exception that “unless the child’s non-attendance follows attendance for three (3) successive quarters with intent to return during the fifth quarter or two (2) successive semesters with intent to return during the fourth semester” has been deleted inasmuch as Coverage will now cease when full-time attendance at an accredited school ceases.

In 111-4-1-.09(8), wording has been added to clarify that Premium payment must be received “in full,” unless suspension in benefit payment will occur.

In 111-4-1-.09(10), the eliminated term “Subscriber” has been replaced twice with the appropriate defined term “Retiree.” The word “participating” has been inserted indicating that the retirement system must be a participating one. And, the general reference to 111-4-1-.07 replaces the more specific reference to 111-4-1-.07(4) as the general reference appropriately reflects the intent.

In 111-4-1-.09(11)(a), the word “full” has been inserted in front of the term “Premium” and the word “amount” has been inserted immediately behind it, indicating that the full Premium amount must be paid.

In 111-4-1-.09(11)(b) the newly defined term “Coverage” has been inserted as it appropriately conveys the meaning of the provision.

In 111-4-1-.09(12), the words “single Tier” has been replaced with the new phraseology “employee only” indicating Coverage only for the Employee. Also, a reference to an Employee “enrolled in family Tier” has been replaced with the words “when the Coverage includes Dependents,” as “family Tier” will no longer be included in the terminology. Finally, the specific reference to 111-4-1-.09(11) has been deleted and has been replaced with a more general all-encompassing reference to “the Extended Coverage provisions of these regulations.”

Wording has been revised and shifted in 111-4-1-.09(13) stating that the Administrator may require documentation of other Coverage, but the meaning has remained the same.

In 111-4-1-.09(14), the word “submit” has been replaced with the more appropriate word “remit.” The words “proper and timely” have been deleted and the

words “required by the Plan” have been inserted indicating that payments must be submitted within the time period required by the Plan. Also, the words “for Enrolled Members of the Employing Entity” have been inserted clarifying that it is the Enrolled Members who may have benefit Coverage suspended if payments are not submitted within the time requirements set by the Plan.

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.— **May 25, 1983.** Approval was given for an effective date of July 1, 1983;~~
- ~~2.— **June 22, 1983.** Approval was given to adopt the regular insurance, High Option, for an effective date of August 1, 1983;~~
- ~~3.— **June 18, 1986.** Approval was given for implementing the utilization review program in the Standard and High Options for an effective date of November 1, 1986;~~
- ~~4.— **March 18, 1987.** Approval was given for increasing the maximum coverage amounts to \$500,000 during a calendar year and \$1,000,000 lifetime;~~
- ~~5.— **December 20, 1988.** Approval was given for implementing a mandatory utilization review program that installs penalties for non-compliance and repeals the hospital deductible waiver effective June 1, 1989; for clarifying mental health coverages and maximums effective March 1, 1989; for limiting rehabilitative and other outpatient services; for excluding specific procedures effective March 1, 1989; for adding the subrogation contractual provision effective March 1, 1989; and for approving the concept of adding a mail order drug prescription program effective June 1, 1989;~~
- ~~6.— **June 22, 1989.** Approval was given for clarifying the addictive disorders provision effective July 1, 1989;~~
- ~~7.— **October 4, 1989.** Approval was given to eliminate the calendar year maximum coverage amount effective January 1, 1990;~~
- ~~8.— **December 19, 1989.** Approval was given to implement a claim direct prescription drug benefit effective as soon as feasible (Note: Determined to be September 1, 1990);~~
- ~~9.— **February 22, 1990.** Approval was given to implement a hospice care program effective January 1, 1990 and to increase deductibles and maximum out-of-pocket costs effective January 1, 1991;~~
- ~~10.— **October 30, 1990.** Approval was given to modify the hospice care program, adding a preventive benefit program and modifying the chiropractic benefits effective January 1, 1991;~~

~~11. **March 28, 1991.** Approval was given to modify the coverage for organ and tissue transplants and authorizing specialty contracts effective July 1, 1991;~~

~~12. **March 26, 1992.** Approval was given to add an outpatient utilization review program for designated outpatient surgical and diagnostic procedures effective on July 1, 1992;~~

~~13. **May 28, 1992.** Approval was given to amend the prescription drug benefit to clarify the specific benefit coverages, authorize a pharmacy network, establish the reimbursement levels, and authorize electronic transfer of transactions to become effective on October 1, 1992;~~

~~14. **February 25, 1993.** Approval was given to amend coverage for two surgical procedures effective March 1, 1993, to modify the notification time for compliance with utilization review processes effective July 1, 1993, and to clarify the authorization for specialty contracts to become effective March 1, 1993;~~

~~15. **January 26, 1995.** Approval was given to implement a managed behavioral health care benefit effective July 1, 1995;~~

~~16. **February 23, 1995.** Approval was given to delay the implementation of the managed behavioral health care benefit until August 1, 1995 and modify the transition benefits for calendar 1995.~~

1.17. **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;

2.18. **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;

3.19. **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;

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

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

6.22. **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;

7.23. **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;

~~24. May 24, 2001. Approval was given to comply with the Women's Health and Cancer Rights Act of 1998 for an effective date of July 1, 1999;~~

~~8.25. 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;~~

~~9.26. 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;~~

~~10.27. 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;~~

~~11.28. 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 Subscriber/Member shall have the right to ask for a record review by medical consultants.~~

~~(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 Subscriber/Member to appeal an adverse determination of eligibility for Ceoverage or of a~~

benefit, service, or Celaim. These procedures shall be outlined in the Summary Plan Description to advise the SubscriberMember 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 shall establish procedures to ascertain that providers of medical services and supplies are certified or licensed by the appropriate authority when claim payments for services rendered or supplies purchases are requested.~~

~~(h) The Administrator shall establish procedures to terminate benefit payments if continuation of treatment in the mode being billed is not medically necessary. The Subscriber shall have the right to ask for a record review by medical consultants.~~

~~(g)(i)~~ 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)(j)~~ 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 SubscriberMember 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 Subscriber'sMember'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 SubscriberMember 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 SubscriberMember 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 SubscribersMembers of the family are transferred from one Sspouse to the other Sspouse 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 otherover 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 SubscriberMembership 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 ~~D~~ependent child of the parent whose birthday occurs first in the calendar year; or

(iii) When the patient is covered as the eligible and unmarried ~~D~~ependent 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 ~~S~~ubscriber~~M~~ember 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 ~~S~~ubscriber~~M~~ember or eligible ~~D~~ependents are covered by another plan as an Employee and under this Health Benefit Plan as a Retired Employee or Extended Beneficiary, ~~surviving spouse of an Employee~~, or ~~D~~ependent of the Retired Employee or ~~S~~urviving ~~S~~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 ~~S~~ubscriber~~M~~ember 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 ~~S~~ubscriber~~M~~ember reaching age sixty-five (65), the Administrator shall notify the ~~S~~ubscriber~~M~~ember 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 ~~S~~ubscribers~~M~~embers 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 ~~S~~spouse, who is age sixty-five (65) or older, of a ~~S~~ubscriber~~M~~ember who continues to

work has chosen the SHBP as the primary payor, unless the SubscriberMember or his Spouse otherwise notifies the Administrator.

(c) When retired SubscribersMembers or their eligible Dependents are enrolled in ~~entitled to~~ Medicare, ~~even if not enrolled~~, the Regular Insurance 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 ~~electd reduced to the difference between the benefits paid by Medicare for the Plan's covered and eligible charges and the amount of benefits that the Plan would have paid had the Plan been the primary payor for those eligible charges~~. 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 SubscriberMember 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 ~~and B~~ B and D of Medicare, the Subscriber'sMember'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 SubscribersMembers who were not informed of the increased premium when the SubscriberMember was first eligible for Medicare enrollment or for SubscribersMembers who are not eligible for Parts A ~~and B~~ 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 ~~F~~unds from the General Treasury, the ~~h~~Health ~~b~~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 ~~B~~enefits, ~~C~~overages, and eligibility requirements at any time, subject only to reasonable advance notice to its ~~Subscribers~~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 ~~Subscribers~~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 ~~Subscriber~~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 ~~Subscriber~~Member or eligible ~~D~~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.

Authority O.C.G.A. Secs. 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. **History.** Original Rule entitled "Plan Benefits" adopted. F. Apr. 18, 2005; eff. May 8, 2005.

PROPOSED RULE
OF THE
GEORGIA DEPARTMENT OF COMMUNITY HEALTH
RULE 111-4-1-10

STATEMENT OF PURPOSE AND MAIN FEATURES OF PROPOSED RULE:

The purpose of this proposed rule is to make the rules and regulations consistent with anticipated business operation changes.

DIFFERENCES BETWEEN EXISTING RULE AND PROPOSED RULE:

Errors in capitalization have been corrected.

Throughout this subsection, the appropriate forms (singular, plural, or possessive) of the newly defined terms “Member,” or “Enrolled Member” replace the words “Employee” or “Subscriber,” as necessary and appropriate. Also, the eliminated term “Subscriber” has been replaced by the word “membership,” where appropriate.

The word “calendar” has been placed in front of the words month(s) or day(s) in several places throughout the section clarifying that the time period will be either consecutive calendar months or days as appropriate.

Any subsection has been appropriately renumbered or re-lettered if necessary as a result of additions or deletions to the section.

References to the newly codified Medicare Part D have been inserted where necessary.

111-4-1-.10(1)(a)(1) through 111-4-1-.10(1)(a)(16) have been deleted inasmuch as the changes have already been published and are not necessary for inclusion in this revision of the regulations.

111-4-1-.10(1)(a)(24) has been deleted inasmuch as the change has already been published and is not necessary for inclusion in this revision of the regulations.

Wording has been added to the newly renumbered 111-4-1-.10(1)(a)(11)(ii) clarifying that the Administrator shall “authorized the use of” established procedures “by the TPA” to terminate benefit payments when treatments being billed are not medically necessary. The new wording provides more clarity towards the intent.

In the newly renumbered 111-4-1-.10(1)(c) the words “to be used by the TPA” have been added clarifying that the Administrator may need and allow use of benefit information for the TPA’s handling.

In the newly renumbered 111-4-1-.10(1)(d) the words “by the TPA” have been inserted clarifying that the Administrator will allow preauthorization by the TPA.

The words “authorize use of” and “by the TPA” have been added to 111-4-1-.10(1)(e) indicating that the Administrator may allow the TPA to collect additional medical information when necessary.

Wording has been added to the newly renumbered 111-4-1-.10(1)(f) clarifying that the Administrator has delegated final authority for benefit approval in accordance with the schedule of Benefits to the TPA. Language has also been added stating that the final authority for approval of eligibility appeals remains with the Administrator.

The former 111-4-1-.10(1)(g) and 111-4-1-.10(1)(h) have been deleted inasmuch as the changes have already been published and are not necessary for inclusion in this revision of the regulations.

The word “other” replaces the word “over” in 111-4-1-.10(3) inasmuch as “other” is the appropriate word for use in the context of the sentence.

In 111-4-1-.10(3)(c)(5), the words “Surviving Spouse of an Employee” have been deleted as they are not necessary to convey the meaning of the provision.

In 111-4-1-.10(4)(c), the words “enrolled in” replace the words “entitled to” and the words “even if not enrolled” (along with the comma) have been deleted inasmuch as the retired Member must be enrolled in Medicare for the coordination in this subsection to occur. As such, language has been revised to state that coordination will occur in accordance with the Plan Option elected and the previous language has been deleted.

~~111-4-1-.11 Health Maintenance Organizations.~~

~~(1) **Health Maintenance Organization Act.** The health maintenance organization (HMO) act shall mean Section 1310 of the Public Service Act, as amended (42 USC 300c) and Chapter 21 of Title 33 of the Official Code of Georgia Annotated.~~

~~(2) **Eligible Subscriber.** An HMO eligible Employee or Retiree is a Subscriber who meets the eligibility requirements of a specific qualified HMO(s) which has been approved by the Board to be included in the SHBP.~~

~~(3) **Federal Regulations.** Federal regulations mean the regulations promulgated by the Department of Health and Human Services (42 CFR).~~

~~(4) **Procurement of HMOs.** HMOs to be offered by the Plan shall be procured in accordance with a process as determined by the Commissioner with instruction outlined in a request for proposal.~~

~~(a) The proposal shall include the minimum requirements specified by the Commissioner.~~

~~(b) All proposals for inclusion shall be evaluated according to the criteria outlined in the Request for Proposal.~~

~~(5) **HMO Eligibility.** HMOs shall be required to establish the same eligibility requirements as are provided in the Plan, unless the Regulations promulgated by the Insurance Commissioner requires a modification. All contracts with HMOs effective on or after July 1, 1981, shall provide for conformity to the Plan eligibility requirements unless otherwise required by State Law or Insurance Commissioner Regulations.~~

~~(6) **HMO Access to Employees.** A qualified HMO which has been approved to be included in the SHBP shall be provided fair and reasonable access, not less than thirty (30) days prior to and during the group enrollment period, to eligible Employees for the purpose of presenting and explaining its program. This access shall include the opportunity to distribute educational literature, brochures, announcements of meetings and other relevant printed materials which are approved by the Commissioner or his designee.~~

~~(7) **HMO Access to Retirees.** A qualified HMO which has been approved to be included in the SHBP shall be provided fair and reasonable access, at a time specified by the Commissioner, to eligible Retirees for the purpose of presenting and explaining its program. This access shall include the opportunity to distribute educational literature, brochures, announcements of meetings and other relevant printed materials which are approved by the Administrator.~~

~~(8) **Review of HMO Offering Materials.** All materials to be distributed to Employees must be approved by the Commissioner or his/her designee. Revisions to the material shall be limited to correction of factual errors and misleading or ambiguous statements unless agreed to by the HMO and the Commissioner.~~

~~(9) **Enrollment Periods.** The group enrollment period for Employees shall be the Open Enrollment Period in accordance with Section 111-4-1-.06(1). The Commissioner shall recommend if and when Retirees shall be offered the HMO coverage on a Retiree Option Change Period basis.~~

~~(10) **Pre-existing Conditions Prohibited.** Coverage in an HMO shall take effect without application of waiting period or exclusion or limitation based on health status as a condition of enrollment in the HMO Option or transfer to another Plan Option from the HMO, except as provided for new Employees.~~

~~(11) **Selection.** During the enrollment periods or Retiree Option Change Period, only the eligible Subscriber desiring to change is required to complete the affirmative selection. The Commissioner may establish default Option changes when an Option is being eliminated and the Subscriber fails to submit an affirmative selection.~~

~~(12) **Continuation While on Approved Leave of Absence.** The Administrator is authorized to establish procedures for collecting the HMO premium for an Employee whose salary payment is interrupted by an approved leave of absence.~~

~~(13) **Coordination of Benefits.** In a situation where the Employee, spouse, or dependent is covered under an HMO Option and the Regular Insurance, the claim payments will be coordinated so that only one hundred percent (100%) of covered and eligible expenses under the regular insurance Options will be paid. Coordination of Benefits for the regular insurance Options in which the person is enrolled shall be determined in accordance with Section 111-4-1-.10(3) in all cases where the Employee, spouse, and dependents are covered in an HMO Option and a regular insurance Option.~~

~~(14) **Extended Benefits.** Any person, whether Employee, Retiree or Covered Dependent, whose enrollment is changed from one Option to another and who on the effective date of such change is hospitalized, shall be granted a continuation of benefits of the prior Option with respect to the cause of such hospitalization. Such continuation shall not extend beyond the ninety first (91st) day following the last day of enrollment in the prior Option. Upon change of enrollment to the Option, a person so hospitalized on the effective date of the change shall not be entitled to payment for benefits with respect to the cause of such hospitalization while that person is entitled to continuance of benefits under the prior Option.~~

~~(15) **Extended Benefits Limited.** Any person enrolling in an HMO shall not be covered by extended benefits, including pregnancy, childbirth, or any other existing illness, with the regular insurance Options except as stated in the preceding paragraph.~~

Authority O.C.G.A. Secs. 20-2-881, 20-2-884, 20-2-911, 45-18-2, 45-18-6. **History.** Original Rule entitled "Health Maintenance Organizations" adopted. F. Apr. 18, 2005; eff. May 8, 2005.

PROPOSED RULE
OF THE
GEORGIA DEPARTMENT OF COMMUNITY HEALTH
RULE 111-4-1-.11

STATEMENT OF PURPOSE AND MAIN FEATURES OF PROPOSED RULE:

The purpose of this proposed rule is to make the rules and regulations consistent with anticipated business operation changes.

DIFFERENCES BETWEEN EXISTING RULE AND PROPOSED RULE:

Section 111-4-1-.11 entitled “Health Maintenance Organizations” has been deleted in its entirety inasmuch as no business need exists to have a separate section on HMOs (since the regulations address the operation of all of the SHBP’s Managed Care Plans) and each HMO enters into a contract with the Department, which addresses any issue specific to the HMO’s operation.

111-4-1-.~~1112~~ Claims.

(1) **Filing Claims.** The Administrator shall coordinate the procedures for filing claims with the TPA. Claim forms shall be designed and printed for the Subscribers' Member's and providers' use when appropriate.

(2) **Liability Period.** All Celaims of Benefits must be presented in writing to the Administrator or TPA within ~~six (6)~~ twenty-four (24) calendar months following the month of service in which the service was rendered.; ~~except those claims where SHBP is the secondary payor, in which case the liability period shall be twelve (12) months following the month of service.~~ If any Celaim for Benefits is presented to the Administrator or TPA after two (2) years from the date the service was rendered, benefits will not be owed or paid.

(3) **Unclaimed or Uncashed Claim Checks.** All drafts issued on behalf of the Plan shall be void if not presented and accepted by the drawer's bank within six (6) calendar months of the date the draft was drawn. If the payee or Subscriber does not present the draft or request a reissue of the draft for a period of seven (7)~~five (5)~~ years from the date the draft was drawn, the draft will be void and funds retained in the appropriate trust Fund.

Authority O.C.G.A. Secs. 20-2-881, 20-2-890, 20-2-911, 20-2-917, 45-18-2, 45-18-11. **History.** Original Rule entitled "Claims" adopted. F. Apr. 18, 2005; eff. May 8, 2005.

PROPOSED RULE
OF THE
GEORGIA DEPARTMENT OF COMMUNITY HEALTH
RULE 111-4-1-.12

STATEMENT OF PURPOSE AND MAIN FEATURES OF PROPOSED RULE:

The purpose of this proposed rule is to make the rules and regulations consistent with anticipated business operation changes.

DIFFERENCES BETWEEN EXISTING RULE AND PROPOSED RULE:

Section 111-4-1-.12 is being renumbered as 111-4-1-.11 due to the deletion of the previous section 11.

Throughout this subsection, the appropriate forms (singular, plural, or possessive) of the newly defined terms “Member,” or “Enrolled Member” replaces the words “Employee” or “Subscriber,” as necessary and appropriate.

The word “calendar” has been placed in front of the word month(s) throughout the section clarifying that the time period will be consecutive calendar months.

In 111-4-1-.11(2), the time frame for submitting claims to the Administrator has been changed from six (6) months to twenty-four (24) to be consistent with the Plan’s current policy. Also, the reference to a 12-month period for submission of claims where the Plan is secondary has been stricken to be consistent with the Plan’s current policy.

In 111-4-1-.11(3), the time frame for submitting for re-issuance of a draft has been extended to seven (7) years as opposed to five (5) consistent with statutory requirements.