SYNOPSIS

Rule 111-4-1.01
(formerly 478-6.01)

STATEMENT OF PURPOSE AND MAIN FEATURES OF PROPOSED RULE

The proposed amendment modifies the existing regulation in light of changes in the governing statute(s), specifically changes made by Ga. L. 1999, p. 296, § 1, enacted at the 1999 session of the General Assembly, which created the Department of Community Health and transferred the responsibility for administration of the law governing the State Health Benefit Plan to that agency.

DIFFERENCES BETWEEN EXISTING AND PROPOSED RULES

The existing regulation, 478-6.01, is repealed and reenacted as 111-4-1.01, as modified, with the rules and regulations of the Department of Community Health.

Cites within the text have been corrected to reflect the new rule numbers.

Grammatical errors and errors in capitalization have been corrected.

Headings have been bolded for ease of identification of subsections.

Dates at the end of each subsection reflecting the updated changes to the regulations have been removed.

Any citation to authority at the end of a subsection has been removed and listed at the end of this section.

All references to Plan members are removed and replaced with the term “Subscriber” to reflect contract holders of the Plan.

The words “Subparts 1 and 2 of Part 6” in 111-4-1.01 subsection 3 have been changed to “Articles 880 and 910” in order to reference specifically those sections of Chapter 2 of Title 20 that address eligibility under the Plan.

A reference to O.C.G.A. § 31-5A-3 has been referenced within the definition of “Board of Community Health” or “Board” in 111-4-1.01 subsection 10 inasmuch as that code section authorizes the Board’s jurisdiction over the Plan.

A definition of the term “Certificated Capacity” has been added to reflect the Department’s use of the term.

A definition of the term “Certificated Position” has been added to reflect the Department’s use of the term.

The term “Coverage Tier” or “Tier” has replaced the term “Coverage Type” to indicate the type of contract offered to a Subscriber.

The acronym “HMO” replaces the term “health maintenance organization” throughout this section of the regulations.

The definition of “Dependent” in 111-4-1.01 subsection 23 has been modified to include language about other children that live with the Subscriber permanently and are legally dependent on the Subscriber for financial support.

Wording has been added to the definition of “Disabled Student” in 111-4-1.01 subsection 24 that allows the Administrator discretion in determining eligibility for a disabled student when the record indicates less than full time status for that Disabled Student.

The definition of “Full Time Attendance” in 111-4-1.01 subsection 28 has been modified to include language that qualification for full time attendance ceases at the end of the month in which coursework is completed or the student stops attending school.

The definition of “Member” in the former 478-6-.01 subsection 33 has been deleted and is replaced by the definition of “Subscriber” in 111-4-1.01subsection 53.

The word “regular” is deleted from the definition of “Plan” or “Health Insurance Plan” in 111-4-1.01 subsection 38 inasmuch as the definition includes all Plan Options.

A definition of “Plan Options” has been added in order to describe the insurance Options offered under the Plan to Subscribers and their dependents.

The word “tier” was added in 111-4-1.01 subsection 42 to use the defined term.

Wording of the definition of “Qualifying Event” has been rearranged for clarity of meaning.

The definition of “Regular Insurance” has been modified to include new Plan Options.

A definition of “Service Area” has been added in 111-4-1.01subsection 49 and references the geographic area in which a healthcare provider network contracts to provide medical care.

A definition of “Subscriber” has been added in 111-4-1.01subsection 53 to reflect contract holders of the Plan.

A definition of “Summary Plan Description” has been added in 111-4-1.01subsection 54 as a description of the booklet describing the provisions of the Plan.

The word “Retiree” replaces the word “Retired Employee” in 111-4-1.01subsection 55 as the two are interchangeable as defined in 111-4-1.01 subsection 47.

478-6.01 REPEALED.

REGULATIONS
OF
COMMUNITY HEALTH BOARD

CHAPTER 111-4-1
HEALTH BENEFIT PLAN

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 preaccredited by accrediting associations that are recognized by the United States Secretary of Education; or

   B. Any professional, technical, occupational and specialized school accredited or preaccredited 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) or111-4-1.01(1)(B); 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 is receiving compensation or is on approved leave 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 health 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, Legislative Retirement System, Superior Court Judges Retirement System, District Attorney's Retirement System, Teachers Retire-

ment System, Public School Employees' Retirement System, local school system retirement system or Fulton County Retirement System.

7. "**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. "**Beneficiary**" means an Employee, surviving spouse, divorced or legally separated spouse, or eligible dependent child who loses coverage under these regulations.

9. "**Benefits**" mean the schedule of benefits approved by the Board of Community Health for determining the payment amounts.

10. "**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. "**Cafeteria Plan**" means a plan which meets the requirements of the Regulations of the Internal Revenue Service under IRC 125.

12. "**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. "**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 Teacher's Retirement System or other public school teachers retirement system.

14. "**Claim**" means the approved form(s) for presenting a request for determination of the payment amount due to an Employee, Extended Beneficiary, or assignee. 15. "**Commissioner**" means the Commissioner of the Department of Community Health as created by O.C.G.A § 31-5A-6
16. "**Contract Employee**" means a person employed by one of the entities that contracts with the Board of Community Health to provide health benefit coverage under the SHBP, and who is not considered to be an independent contractor.
17. "**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. "**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 coverage.

19. "**Coverage Tier**" or "**Tier**" means the type of contract offered to a Subscriber.

20. "**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. "**Creditable Coverage**" means health insurance coverage that may serve to reduce a pre-existing condition coverage limitation period. Creditable coverage shall include health coverage under the following type plans: group health plans; individual health policies; health maintenance organizations (HMOs) Medicaid; Medicare; or other governmental health programs. Disease-specific coverage (i.e., cancer insurance), disability insurance, and insurance that provides incidental health benefits (i.e., auto insurance) is not creditable coverage.

22. "**Deduction**" or "**Reduction**" means the 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. "**Dependent**" means any eligible spouse, dependent child, full-time student, or totally disabled child or other child(ren) if the children live with the subscriber permanently and are legally dependent on the subscriber for financial support.

24. "**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. "**Employee**" means any eligible, Active State Employee, teacher, or public school Employee.
26. "**Employing Entity**" means any department, school system, local 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.
27. "**Extended Beneficiary**" means the individual who was covered as an Active or Retired Employee, Employee on approved leave of absence without pay or person who was covered as a spouse or eligible dependent of an Active or Retired Employee or Employee on approved leave of absence without pay on the day SHBP coverage was lost as a result of a qualifying 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 accredited institution's full-time status. A withdrawal, from some coursework that reduces the number of hours to less than full-time during the quarter.will not affect full-time attendance 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). Full-time attendance ends at the end of the month in which course work is completed or if the student ceases attendance.

29. "**Fund**" or "**Health Benefit Fund**" or "**Health Insurance Fund**" means the state employees health insurance fund, the teachers health insurance fund, and the public school employees health insurance fund.

30. "**Group**" means all eligible Employees authorized under a specific chapter, article or part of the Official Code of Georgia Annotated for 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. "**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 for Medicare enrolled Retirees.

34. **"Option**" means the type of benefit schedule or premium rating category that is offered to the Subscriber through regular insurance or an HMOs.

35. "**Partial Disability**" means the Subscriber 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. "**Payor, Primary**" means the entity which is required by contract or law to reimburse or pay for medical care treatment without regard to any other benefit entitlement or contractual provision.
37. "**Payor, Secondary**" means the entity which does not have the primary liability for providing benefit reimbursement for medical care treatment.

38. "**Plan**" or "**Health Insurance Plan**" means the insurance Options formed by the combination of health insurance plans for state Employees, teachers, and public school 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 anHMO.
40. "**Plan Year**" means the twelve-month period beginning on July 1, and ending on the following June 30.

41. "**Pre-existing condition**" 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 months immediately before coverage began under the Plan. Genetic status is not a pre-existing condition unless diagnosis, care or treatment was rendered within the six-month period. (Health Insurance Portability and Accountability Act of 1996)

42."**Premium**" means the Subscriber's cost as set by the Board of Community Health for the Coverage Tier and Option.

43. "**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. "**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 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. **Rate**" means an amount set by the Board for the Subscriber premium or an amount or percentage of salary set by the Board as the employer's contribution.

46. "**Regular Insurance**" means the self-insured "PPO Basic", "PPO Premier" "PPO Choice Basic", "PPO Choice Premier", "Indemnity Basic" and "Indemnity Premier" Options that are offered on a statewide basis.
47. "**Retired Employee**" or "**Retiree**" means a former state Employee, former teacher, or former public school Employee who met the eligibility criteria when active or was included by specific legislation and who receives a monthly benefit from the Employees Retirement System, Legislative Retirement System, Teachers Retirement System, Public School Employees Retirement System, Superior Court Judges Retirement System, District Attorney's Retirement System, or local school system retirement system and an eligible and former Employee of a county department of family and children service 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 active Employee and continued coverage upon receiving an annuity from the Fulton County Retirement System. Retiree shall also include Subscribers who remit payment directly to the SHBP and who are eligible for coverage as a surviving spouse of the eligible Employee or Retiree, an Extended Beneficiary who is eligible by virtue of State law, or an annuitant whose monthly benefit from a retirement system is insufficient to pay the premium for the Option in which enrolled.

48. "Retiring Employee" means a covered Subscriber who is eligible to receive an immediate retirement benefit payment from the Employees Retirement System, Legislative Retirement System, Teachers Retirement System, Public School Employees Retirement System, Superior Court Judges Retirement System, District Attorney's Retirement System or local school system retirement system or an eligible 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 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 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. "**Summary Plan Description**" is a booklet that describes the provisions of the State Health Benefit Plan (SHBP) .

55. "**Surviving Spouse**" means the living spouse of a deceased Employee or Retiree.

56. "**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.

57 "**Total Disability**" means that the 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."**TPA**" or "**Third-party Administrator**" means an approved contractor for adjudicating claims, paying claims, and performing other administrative processes.,

Authority: O.C.G.A. §§45-18-2, 20-2-881, 20-2-892, 20-2-911, Health Insurance Portability and Accountability Act of 1996 (HIPAA)

SYNOPSIS

Rule 111-4-1.02
(formerly 478-6.02)

STATEMENT OF PURPOSE AND MAIN FEATURES OF PROPOSED RULE

The proposed amendment modifies the existing regulation in light of changes in the governing statute(s), specifically changes made by Ga. L. 1999, p. 296, § 1, enacted at the 1999 session of the General Assembly, which created the Department of Community Health and transferred the responsibility for administration of the law governing the State Health Benefit Plan to that agency.

DIFFERENCES BETWEEN EXISTING AND PROPOSED RULES

The existing regulation, 478-6.02 is repealed and reenacted as 111-4-1.02, as modified, with the rules and regulations of the Department of Community Health State Health Benefit Plan.

Cites within the text have been corrected to reflect the new rule numbers.

Grammatical errors and errors in capitalization have been corrected.

Headings have been bolded for ease of identification of subsections.

Dates at the end of each subsection reflecting the updated changes to the regulations have been removed.

Any citation to authority at the end of a subsection has been removed and listed at the end of this section of the regulations.

The term “Coverage Tier” or “Tier” has replaced the term “Coverage Type” to indicate the type of contract offered to a Subscriber and is so used throughout this section of the regulations.

All references to Plan members and Employees when referencing coverage under the State Health Benefit Plan are removed and replaced with the term Subscriber to reflect contract holders of the Plan.

The section referencing the participation of local school systems under the former 478-6.02 subsection 1(d)(3) has been deleted due to a change in Plan operations.

The phrase “or in a Certificated Capacity” has been added in 111-4-1.02 subsection D4 to indicate that employers must contribute for both Certificated Positions and Certificated Capacity.

Reference to the State Personnel Board is removed and replaced with the term Board to reflect the Board of Community Health, which was established by statute at O.C.G.A. §§ 31-5A-4 *et. seq.* to oversee the Department of Community Health, which is responsible for health care policy, purchasing, planning, and regulation.

Language is added in 111-4-1.02 subsection 1D6 to clarify that the employer contribution rate for the State employees health insurance fund shall be a percentage of the total salaries of all employees.

Health maintenance organizations shall be referenced as “HMOs” throughout this section.

The number 30 has been changed to 30.1 and the number 31 has been deleted in 111-4-1.02 subsection 1E1 in order to correct an inaccuracy in the text.

Reference has been deleted to the Board's authority to contract with the Georgia Hazardous Waste Management Authority.

Wording has been added in 111-4-1.02 subsection 1E3 to indicate that the Plan may contract with any public or non-profit critical access hospital pursuant to O.C.G.A. §45-18-7.4.

The submission of any amounts available for investment shall be made to the Office of Treasury and Fiscal Services as opposed to the Fiscal Division of the Department of Administrative Services. The Director of the Office of Treasury and Fiscal Services shall deposit funds designated for the Plan in a trust account.

Language has been added in 111-4-1.subsection 2B(4) to reflect that the Commissioner may discharge a debt of $400.00 or less.

References to the summary plan document have been changed to Summary Plan Description or SPD.

The word "dependent" has been added to 111-4-1.02 subsection 2H to indicate that each dependent will be issued an identification card.

The Commissioner may either mail identification cards to the Subscriber's home address or require the Employing Entity to distribute Identification Cards to Subscribers following Open or Special Enrollment periods unless the Subscriber elected coverage under an HMO.

The definition of the term "administrative error" is modified from the previous rule to reflect that an administrative error must be clerical in nature and is left to the discretion of the Administrator.

Reference to the term Plan booklet is changed to Summary Plan Description (SPD).

It shall be the duty and responsibility of the Employing Entity to abide by the Plan's regulations.

Language is changed to reflect that Employing Entities shall assist eligible new Employees in the enrollment process. The Employing Entity shall require each "eligible" new Employee to complete an enrollment form within 31 calendar days of reporting to work.

The Employing Entity shall deduct premiums as authorized by the Georgia Code.

The Employing Entity must assume the responsibility for reconciling the premium payments and the billing invoice, making any corrections within 30 days of receiving the bill.

Language inserted to indicate that the Employing Entity shall include administrative fees in its calculations for either enrolling or continuing coverage during leave under the Family Medical Leave Act.

The requirement that each local or State employer distribute a Plan booklet to each covered Employee has been deleted inasmuch as Plan operations have changed.

Employing Entities shall make available to eligible Employees all available benefit information necessary for Subscribers to make informed health benefit decisions.

The process of distributing Plan materials to Employees will require Employing Entities to make every effort to distribute Plan materials required by the Plan.

Employing Entities will be required to reimburse the Plan 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.

The subsection which allows local school systems to have the Option to determine whether or not the Employees who would otherwise be eligible as public school Employees shall be covered by the Plan has been deleted as it is no longer operational.

478-6.02 REPEALED.

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 health insurance plan for group hospitalization and surgical and medical insurance against the financial costs of hospitalization, surgery, and medical treatment and care. The plan may also include, but is not required to include, prescribed drugs, medicines, prosthetic appliances, hospital inpatient and outpatient service benefits, dental benefits, vision care benefits, 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 to be included and the expected distribution of expenses of each such type to be incurred by the covered Employees and dependents;
   (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 stability in future years of the Plan; and

   B. **Promulgate Regulations**. The Board is authorized to adopt and promulgate rules and regulations for the effective administration of the SHBP; to adopt and promulgate regulations for defining the contract(s) for retiring Employees and their spouses and dependent children; to adopt and promulgate regulations for prescribing the conditions under which an Employee or retiring Employee may elect to participate in or withdraw from the SHBP; to adopt and promulgate regulations defining the conditions for covering the Employee's spouse and dependent children and for discontinuance and resumption by Employees of coverage for the spouse, surviving spouse, and dependents; to adopt and promulgate regulations to establish and define terms and conditions for former and terminated Employee participation; adopt and promulgate rules and regulations which define the conditions under which 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.

   C. **Establish Subscriber Premium Rates**. The Board shall establish 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 deduction amount. Other Subscriber premium amounts shall be established in accordance with these regulations. All Subscriber premium rates shall be established by resolution and shall remain in effect until changed by resolution.

   D. **Establish Employer Rates**. The Board shall establish by resolution, subject to the Governor's approval, employer contribution rates. These rates may be a dollar amount, a dollar amount for each enrolled Employee, a percentage of salary or any other method permitted by law.

      (1) The employer contribution rate for teachers who retired prior to January 1, 1979 shall be a dollar amount as identified in the appropriations.

      (2) The State Department of Education employer contribution rate for the public school employee health insurance fund shall be a dollar amount as identified in the appropriations act.

(3) The local school system employer contribution rate for the public school employee health insurance fund shall be a dollar amount per actively enrolled public school employee and shall be remitted to the Administrator on a monthly basis. The employer's contribution amount shall be due on the first of the month coincident with the employees' monthly premium amounts.

(4) The employer contribution rate for the teachers health insurance fund shall be a percentage of the salary approved by the State Board of Education under the Quality Basic Education Act for persons holding "Certificated Positions" or in a "Certificated Capacity". The monthly employer contribution shall be a percentage of state based salaries. County or district libraries shall pay as the employer contribution the Board approved percentage of total salaries, exclusive of per diem and casual labor, which is defined as part-time Employees who work less than 18 hours per week. The contribution amount shall be due to the Administrator on the first of the month coincident with the Employees' monthly coverage payment. The Commissioner is authorized to establish necessary procedures to implement the receipt of the employer contribution on a timely and accurate basis. (

(5) The employer contribution rate for the State employees health insurance fund shall be a percentage of the total salaries of all Employees. Total salaries include temporary salaries, overtime pay, terminal leave pay, and all types of supplemental pay. The monthly employer contribution shall be based on salaries for the previous month and shall be due on the first of the month coincident with the Employees' monthly premium amounts. (

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

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

(2) **Self Insurance**. The Board in its discretion may establish a self-insured plan in whole or in part. The contract for Administrative Services in connection with a self-insured health benefit plan may be executed with an insurer authorized to transact accident and sickness insurance in Georgia; with a hospital service nonprofit corporation, nonprofit medical service corporation, or health care corporation; with a professional claim Administrator authorized or licensed to transact business in Georgia; or with an independent adjusting firm with

Employees who are licensed as independent adjusters pursuant to Article 2 of Chapter 23 of Title 33.

(3) **Local Governments**. The Board is authorized to contract with the various counties of Georgia, to contract with the Georgia Cooperative Services for the Blind, to contract with 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 Georgia Housing and Financing Authority, any public or non-profit critical access hospital, the Georgia-Federal State Inspection Service for the inclusion of Employees, retiring 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 Subscriber's salary the Subscriber's cost of coverage. In the case of the Georgia Development Authority, the Peace Officers' Annuity and Benefit Fund, the Georgia Firefighters' Pension Fund, the Sheriffs' Retirement Fund of Georgia, and the Georgia Agrirama Development Authority, the Retiree's cost of coverage shall be deducted from the Retired Subscriber's annuity payment. In addition, each contract employer shall make the employer contribution required for inclusion in the Plan and remit such payments in accordance with procedures as the Administrator may require

(4) **Other Organizations**. The Board is authorized to contract with other organizations, including any public or nonprofit critical access hospital that meets such requirements as the Administrator may establish for the inclusion of the Employees and dependents in the SHBP. Each employer shall deduct from the Employee's salary the Employee's share of the cost of coverage. Each employer shall remit the total premium amount as established by the Administrator for inclusion of its Employees in the Plan and in accordance with such procedures as the Administrator may require.

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

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

(a) Collect the Subscriber premium amounts for the rates established by the Board; and

(b) Enroll and maintain enrollment at 75% of the eligible public school Employees as defined in these regulations.

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

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

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

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

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

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

(4) The Commissioner may administratively discharge a debt or obligation not greater than $400 due the health insurance fund or funds.

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

D. **Elicit and Evaluate Proposals from Health Care Contractors and/or Administrators**. As required for the appropriate administration of the Plan, the Commissioner shall 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 employer contribution rate for "single" coverage and an average employer contribution for "family" coverage for non-Medicare+Choice enrolled Subscribers based on the method specified in Section 111-4-1.11(14) and 111-4-1.11(16). The Commissioner shall present the employer HMO contribution rates and the Subscriber deduction/reduction amounts for each Option and Coverage Tier to the Board for adoption at least 60 days before the beginning of the State of Georgia's Fiscal Year.

F. **Premium Payments to a Contractor.** The Commissioner shall calculate the premium amounts due to each HMO and to any underwriter of insurance or re-insurance and remit payments from the appropriate trust funds for Subscriber coverage.

G. **Develop and Publish Plan Document**. The Commissioner shall develop a Summary Plan Description (SPD) or certificate of coverage which incorporates the approved schedule of benefits, eligibility requirements, Termination of Coverage provisions, Extended Coverage provisions, to whom benefits will be payable, to whom claims should be submitted, and other

administrative requirements. The Commissioner shall cause the Summary Plan Description to be printed and distributed to each local and state employer for each covered Subscriber. The Commissioner shall distribute the SPD to Retired Subscribers 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 required filing.

I. **Provide Notice of Employer Contribution**. The Commissioner shall provide notice and certification of the required employer contribution rate to each of the Employing Entities and the Department of Education on or before June 1 of each year, if the rate for the ensuing fiscal year is to be modified. The Commissioner shall notify the Employing Entities before the rate is effective of any rate change which may be required at times other than the beginning of a fiscal year. .

J. **Provide Notice of Eligibility**. The Commissioner shall develop procedures for notifying beneficiaries of the Extended Coverage eligibility upon notification by the Employing Entity of the Subscriber's employment termination, death, or reduced hours or upon notification by the Subscriber of divorce, legal separation, or child no longer meeting the definition of dependent.

K. **Provide Certification of Creditable Coverage**. The Administrator shall establish procedures for providing a certificate of creditable coverage to each Subscriber at the time coverage cancels or upon request of the Subscriber or Covered Dependent and for a period of twenty-four months after coverage cancellation. The Subscriber may use the certification to limit a subsequent plan's imposition of a pre-existing condition limitation or exclusion period. Coverage cancellation may be the result of termination of coverage though Employee deduction, termination of coverage at the end of an approved leave of absence without pay, or termination of coverage at the end of the Temporary Extended Coverage period.

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

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

   A. **Enroll Eligible Employees**. Each Employing Entity shall enroll or assist all persons who become full-time Employees and who are eligible under these regulations as Subscribers of the SHBP unless the Employee rejects or waives such coverage in writing. The Employing Entity shall require each eligible new Employee to complete, within thirty-one (31) calendar days of reporting to work, a form for enrolling or a form for declining or waiving coverage under the SHBP. The Employing Entity shall be responsible for collecting any premiums due for the selected coverage.

   B. **Deduct Subscriber Premium Amounts**. The Employing Entity shall withhold the Subscriber premium amount as approved by the Board, or the premium amount authorized by the applicable Georgia Code sections, from his/her compensation as the Subscriber's share of the cost of coverage under the Plan. Any retirement system under which retired or retiring Subscribers may continue coverage under the SHBP as an annuitant shall withhold the premium amount as approved by the Board from his/her annuity as the Subscriber's share of the cost of coverage under the Plan.

   C. **Remit Employee and Employer Amounts**. The Employing Entity shall reconcile their Employee's SHBP coverage records in the manner prescribed by the Administrator 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. The 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 Subscriber's SHBP coverage, as reflected on the SHBP monthly billing statement. Each employer is responsible for reconciling the premium payments and the billing invoice to make any and all corrections to the records. This is to be done within 30 days of 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 Subscriber'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 Subscribers who elect to enroll or continue coverage during an approved Family Medical Leave Without Pay.

   D. **Provide Employee Enrollment Information to the Administrator**. Each Employing Entity shall make available to eligible Employees all educational and benefit enrollment information necessary for the Employee or Subscriber to make an informed health benefit plan decision.

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

F. **Provide Leave Without Pay Information to Subscribers**. Each Employing Entity shall administer a Family and Medical Leave Program in compliance with the federal laws and shall provide information regarding the conditions for continuing coverage under the SHBP to eligible Employees. Each Employing Entity shall also provide continuation of coverage information to Subscribers under other Leave Without Pay provisions of these regulations. Each Employing Entity shall insure Employees on approved leave of absence are properly notified of the annual Open Enrollment Period and afforded the opportunity to enroll or change coverage.

G. **Provide Employee Termination Information to the Administrator**. Each Employing Entity shall report to the Administrator the date of the last deduction and/or the reason for the coverage termination no later than thirty (30) days following the employment termination or loss of eligibility to participate in the Plan through payroll deduction/reduction. The reasons for coverage 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 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, 20-2-911, 20-2-883, 20-2-913, 20-2-55, 20-2-895, 20-2-892, 20-2-920, 20-2-894(b), 20-2-922(b), 20-2-885, 20-2-914, 20-2-912, 20-2-915, 20-2-916,), 20-2-884, 20-2-914(c), 20-2-893, 20-2-922, 20-2-921, 31-5A, 20-2-896, 20-2-924, 20-2-891, 20-2-918, 20-2-919, Consolidated Omnibus Budget Reconciliation Act (COBRA), Treasury Regulation Section 1.125, Family and Medical Leave Act of 1993 (FMLA), Health Insurance Portability and Accountability Act of 1996 (HIPAA).

SYNOPSIS

Rule 111-4-1.03
(formerly 478-6.03)

STATEMENT OF PURPOSE AND MAIN FEATURES OF PROPOSED RULE

The proposed amendment modifies the existing regulation in light of changes in the governing statute(s), specifically changes made by Ga. L. 1999, p. 296, § 1, enacted at the 1999 session of the General Assembly, which created the Department of Community Health and transferred the responsibility for administration of the law governing the State Health Benefit Plan to that agency.

DIFFERENCES BETWEEN EXISTING AND PROPOSED RULES

The existing regulation, 478-6.03, is repealed and reenacted as 111-4-1.03, as modified, with the rules and regulations of the Department of Community Health.

Cites within the text have been corrected to reflect the new rule numbers.

Any citation to authority at the end of a subsection has been removed and listed at the end of this section of the regulations.

Dates at the end of each subsection reflecting the updated changes to the regulations have been removed.

Grammatical errors and errors in capitalization have been corrected.

Headings have been bolded for ease of identification of subsections.

All references to Plan members are removed and replaced with the term “Subscriber” to reflect contract holder of the Plan.

All references to “coverage type” have been changed to “Coverage Tier” or “Tier” and are referenced as such throughout the regulations.

Language in 111-4-1.03 subsection 4 for “Records” has been modified to comply with applicable state and federal law and regulations under the Health Insurance Portability and Accountability Act of 1996 regarding disclosure of medical records and other individually identifying health information.

A provision has been added to 111-4-1.03 subsection 5 to indicate that an employer’s responsibility to notify the Plan of discrepancies in a Subscriber’s coverage is not negated by the Subscriber’s responsibility to do so. The Employing Entity still must fulfill notification and any other requirements as dictated by Plan rules.

111-4-1.03 subsection 4A has been modified to include language requiring that premiums paid through direct pay be in accordance with the coverage selection chosen.

The subsection requiring a Subscriber to bring an error in benefit selection to the attention of the appropriate staff either by the end of the month following three monthly reductions/deductions or by the end of the month following seven semi-monthly reductions/deductions has been deleted due to a change in Plan operations.

Subscribers shall be liable to the Plan for any expenditure incurred by the Plan on behalf of a dependent who fails to meet eligibility requirements for dependents under these regulations.

Language in 111-4-1.03 subsection 4C has been added clarifying that proof of creditable coverage must be supplied to the Administrator.

478-6.03 REPEALED.

111-4-1.03 GENERAL PROVISIONS.

1. **Applicability**. All Employees who become eligible for coverage under the SHBP shall be enrolled or permitted to change Coverage Tier 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 annuitants or Extended Beneficiaries shall be enrolled or permitted to change coverage Tier or Option only in accordance with these regulations.
2. **Extension of SHBP to Eligible Groups**. The Board shall review and approve provisions for extending coverage to eligible groups as required by law. The special provisions may include allowing Employees or beneficiaries to reenroll in the SHBP (7-1-86)

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.

. **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 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. **Subscriber Responsibility**. The Subscriber has responsibility for notifying his/her employer and the Plan of discrepancies in the Subscriber's coverage records. Notwithstanding, the requirements of this provision do not negate the employer's responsibility. The Employing Entity must still fulfill notification and all other requirements set forth under these regulations.

   A. The Subscriber is responsible for assuring that the proper premium payments are deducted or reduced from the Subscriber's salary or retirement benefit for the Option and Coverage Tier that was selected. Premiums of Subscribers that are paid through direct pay are to be paid in accordance with their coverage selection.

   B. The Subscriber is responsible for updating spouse and dependent information and requesting appropriate changes in coverage as the circumstances warrant. The Subscriber 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 12 months from the date that the Administrator receives evidence from the Subscriber that the Plan had no liability for additional covered persons

   C. When the Subscriber 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 member 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. §§45-18-1 *et seq*., 20-2-922, 20-2-894, 20-2-881, 20-2-911, 20-2-897, 20-2-925, 50-18-72, 50-18-94, Health Insurance Portability and Accountability Act (HIPAA).

SYNOPSIS

Rule 111-4-1.04
(formerly 478-6.04)

STATEMENT OF PURPOSE AND MAIN FEATURES OF PROPOSED RULE

The proposed amendment modifies the existing regulation in light of changes in the governing statute(s), specifically changes made by Ga. L. 1999, p. 296, § 1, enacted at the 1999 session of the General Assembly, which created the Department of Community Health and transferred the responsibility for administration of the law governing the State Health Benefit Plan to that agency.

DIFFERENCES BETWEEN EXISTING AND PROPOSED RULES

The existing regulation, 478-6.04, is repealed and reenacted as 111-4-1.04, as modified, with the rules and regulations of the Department of Community Health.

Cites within the text have been corrected to reflect the new rule numbers.

Dates at the end of each subsection reflecting the updated changes to the regulations have been removed.

Any citation to authority at the end of a subsection has been removed and listed at the end of this section of the regulations.

Grammatical errors and errors in capitalization have been corrected.

Headings have been bolded for ease of identification of subsections.

All references to Plan members or employees when referencing coverage under the State Health Benefit Plan are removed and replaced with the term “Subscriber” to reflect contract holders of the Plan.

Headings have been added to subsections for clarity in reading and identifying the subject matter of information.

The words “if classified as the following” are added to 111-4-1.04 subsection 1 in order to set up a reader-friendly classification structure for a structurally comprehensible description of active Employees.

111-4-1.04 subsection 1A(1)-(6) has been restructured for ease of reading, which includes some re-wording of information.

Specially classified employees of the Jekyll Island State Park Authority have been added under the classification of full-time Employees in 111-4-1.04 subsection 1A(2) pursuant to O.C.G.A. § 47-2-313.

The hours in 111-4-1.04 subsection 1B have been changed from 18 to 17 ½ per week to be in compliance with State law.

Wording has been added to the end of 111-4-1.04 subsection 2A to indicate that a Subscriber who is eligible to receive an annuity from any retirement system with which the Board is eligible to contract is eligible to participate in the Plan, including the Judicial Retirement System.

All references to coverage have been changed to "Coverage Tier" or "Tier" and are referenced as such throughout this section of the regulations.

Language is added to 111-4-1.04 subsection 6B to clarify that a Subscriber's employer must approve a return to work on a part-time basis from a period of disability leave or paid leave in order to be eligible to continue coverage under the Plan if the part-time work is part of a process to gradually return the Subscriber to full-time work.

The word "medical" is inserted in 111-4-1.04 subsection 6E3 in order to clarify that the family leave referenced is Family Medical Leave under the Family Medical Leave Act.

The time length approved for Military Leave in 111-4-1.04 subsection 6F has been changed from eighteen (18) months to twenty four (24) months to comply with U.S.E.R.R.A. Guidelines.

The word "timely" is inserted in 111-4-1.04 subsection 6L2 to reiterate that payment must be timely in order to assure continuation of coverage.

Language is added to the beginning of 111-4-1.04 subsection 8D in order to indicate that guardianship requires residency in the Subscriber's home.

Language was modified in 111-4.1.04 subsection (9) (b) to reflect current SHBP practices.

An annuitant is referenced as a Subscriber in 111-4-1.04 subsections 10, 10A, and 11.

Language is added to 111-4-1.04 subsection 11A to emphasize that a surviving spouse of an active Employee may continue coverage provided the retirement system from which the spouse is immediately eligible to receive a monthly payment is state-supported and the surviving spouse receives a sufficient amount to pay the premium. An election by the surviving spouse to take a lump sum payment rather than a monthly annuity negates the spouse's eligibility. The latter portion of this section dealing with eligibility of a dependent child who loses eligibility is deleted as it is addressed in 111-4-1.04 subsection 11C.

Language is added to 111-4-1.04 subsection 11B to emphasize that a surviving spouse of a Retired Employee may continue coverage provided the retirement system from which the spouse is immediately eligible to receive a monthly payment is state-supported and the surviving spouse receives a sufficient amount to pay the premium. An election by the surviving spouse to take a lump sum payment rather than a monthly annuity negates the spouse's eligibility.

Language is added to 111-4-1.04 subsection 11C to emphasize that an eligible dependent child of a deceased active Employee must be the principal beneficiary under a state supported retirement system which provides enough benefit sufficient to pay the monthly premium and also must not be covered as a dependent child under another contract under the Plan in order o be eligible for coverage.

Language is added to 111-4-1.04 subsection 11C to emphasize that an eligible dependent child of a deceased Retired Employee must be the principal beneficiary under a state supported retirement system which provides enough benefit sufficient to pay the monthly premium and also must not be covered as a dependent child under another contract under the Plan in order to be eligible for coverage under the Plan.

Language is added to 111-4-1.-4 subsection 11F to clarify that the surviving spouse of a Retired Employee who is included in coverage at the time of the Subscriber's death and who will not receive a monthly annuity payment from one of the state supported retirement systems shall be eligible to enroll himself or herself and the Subscriber's dependent children at the time of the Subscriber's death provided conditions of 111-4-1.04 subsection 11F(1)-(3) are met.

478-6.04 REPEALED.

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 week 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) A; 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 Code Section 15-18-14, or district attorneys' investigators appointed pursuant to O.C.G.A. 15-18-14.1 of the superior courts of this state;

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

      (7) Full-time Secretaries and Law Clerks who are employed by district attorneys and judges and are employed under Code Sections 15-6-25 through 15-6-28 and Code Sections 15-18-17 through 15-18-19. (7-1-86)

   B. Teachers who are employed not less than half time, which must be at least 17 ½ 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 has 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 Code Section 45-18-5 are eligible to enroll under the conditions of these regulations. Collection and remittance of Subscriber premium and employer contribution amounts shall be in accordance with Code Section 20-2-55 and these regulations.

2. **Retired Subscribers**. Any Employee who was eligible to participate under 111-4-1.6-.04(1)(a), 111-4-1.6-.04(1)(b), or 111-4-1.6-.04(1)(c) and who was enrolled in the Plan at the time of retirement shall be eligible to continue coverage if:

A. The Subscriber is eligible to immediately receive an annuity from the Employees Retirement System, Legislative Retirement System, Judicial Retirement System, Superior Court Judges or District Attorney's Retirement Systems, 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 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 a Subscriber and a Dependent**. In the situation where both husband and wife are eligible to be covered under the SHBP as a Subscriber, each may enroll as a 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 a Subscriber Limited**. In the situation where the Subscriber is entitled to coverage under the SHBP as an Active Employee under a health insurance act and a Retired Employee under a different health insurance act, or any combination of provisions, the Subscriber may choose among the active provisions under which the Subscriber will be covered, but may not choose coverage as a Retiree or beneficiary of a Retiree as long as the Subscriber is eligible for coverage under one of the active provisions. In no circumstance shall the individual be a covered Subscriber under more than one provision of these regulations. ,

5. **Eligibility for Coverage as an Active Employee with Two (2) Employing Entities**. 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.

6. **Employees on Leave Without Pay**. Active Employees who are eligible to participate in the SHBP may continue the Coverage Tier and Option in which enrolled during a period of "approved leave of absence without pay," subject to the conditions in these regulations. Employees who are on suspension or approved leave of absence without pay shall not be eligible to enroll or re-enroll for coverage while on leave without pay under any provision of these regulations except during the annual Open Enrollment period. Except for Military Leave and Military Reservist Activation Leave, coverage shall not be extended for an Subscriber who is self employed or gainfully employed by another party during a period of leave of absence without pay. Application to continue coverage while on leave without pay must be signed within 31 days and filed with the Administrator within sixty (60) days of the termination of paid coverage through payroll deductions. Subscribers who qualify for continued coverage under multiple leave types may continue coverage under a combination of leave types; however, the total period of coverage on Leave Without Pay shall not exceed twelve (12) calendar months, unless otherwise noted in these provisions. Premium payments must be in an amount sufficient to provide continuous coverage between termination of paid coverage through payroll deductions and the beginning of leave without pay coverage. When an Employee on Leave Without Pay enrolls during the annual Open Enrollment, the twelve (12) calendar month coverage period shall be reduced by the number of prior months of approved Leave Without Pay during which the Employee did not participate in the SHBP

A. **Disability Leave**. A Disability Leave is the period of time for which the Employee has been granted an approved leave of absence without pay due to personal illness, accident or disability. Coverage may be continued under this provision for the period of disability, but not longer than twelve (12) consecutive calendar months.

(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 Subscriber whose employer approves his 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 Subscriber 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)

(1) Certification of the partial disability period 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.

C. **Leave of Absence for the Employer's Convenience**. A leave of absence for the employer's convenience is a period of time during which the employer, pursuant to appropriate regulation, places an Employee on approved leave of absence without pay due to a regular programmatic plan for Employee absence. 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 Subscriber 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 Leave**. Family 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 Leave Without Pay for Family Leave may be continued for the period of approved leave, but not longer than twelve (12) weeks in any twelve (12) 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 Employee is ordered to military duty or the period, as provided by law, during which an Employee is attending military training. TheSubscriber may continue the coverage 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 ubscriber may continue the coverage and Option under such leave for the period of absence for persons whose health benefit coverage through payroll deductions ceases after July 1, 1990

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 approved leave of absence without pay is granted for the Employee's convenience. The Subscriber may continue the coverage and Option for the period of suspension or approved leave, but not to exceed twelve (12) calendar months, provided the Subscriber is not self employed or gainfully employed by another party during such leave of absence.

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 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.

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.

M. **Premiums**. Premiums for continued coverage during a period of leave of absence shall be paid monthly. When establishing the monthly premium amount to be paid by the Subscriber, the Board may add a processing fee. The premium rate, excluding the processing fee, shall be based on the type of approved leave. The premium rate for Disability, Family Leave or Military Reservist Activation leave of absence shall be the same as the Employee deduction; the premium rate for all other types of leave shall be the total amount, which consists of the Employee deduction and average employer contribution.

7. **Spouse**. An Active Employee shall be entitled to enroll the Employee's spouse upon employment, during open enrollment, or under conditions specified in Section 111-4-1.6-.06 of these regulations. A Retired Subscriber shall be entitled to continue coverage for the spouse upon retirement or may enroll the spouse in accordance with Section 111-4-1.6-.06(5) or 111-4-1.6-.06(6). ..

8. **Dependent Child**. An Active Employee shall be entitled to enroll eligible dependent children upon employment, during open enrollment, or under conditions specified in Section 111-4-1.06 of these

regulations. A Retired Subscriber shall be entitled to continue coverage for eligible dependent children upon retirement or may enroll eligible dependent children in accordance with Sections111-4-1.06(5). An eligible dependent child is one who is not married nor has been married, except for a legally accepted annulment, and is:

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

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

C. A stepchild who resides in the Subscriber's home 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 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 Subscriber'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 180 days per year; or

D. Guardianship. A Resident in the Subscriber's home in a parent-child relationship and is legally certified as a dependent of the Employee (Retiree) for financial support until the end of the month in which the child reaches age nineteen (19); provided, however, certification of legal dependency is submitted to and approved by the Administrator. Certification documentation requirements are at the discretion of the Administrator; however, a judicial decree from a court of competent jurisdiction is required unless the Administrator concludes that documentation is satisfactory to meet the test of legal dependency and that other legal papers present undue hardship on the Subscriber or living natural parent(s). .

9. **Full-time Student**. An eligible dependent child may be included under the Subscriber's coverage by enrollment, extension or re-enrollment while a full-time student in full-time attendance at an accredited school after age nineteen (19) and until the end of the month in which the child reaches age twenty-six (26), provided the child, if employed, is not eligible for a substantially comparable medical benefit plan at the place of employment.

A. If a full-time student's attendance is interrupted by a period of disability, the Administrator may, upon receipt of appropriate medical information, extend coverage as a temporarily disabled student for the lesser of 12 months or the period of temporary disability. The Administrator shall require documentation of temporary disability no later than 90 days from 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 full-time attendance/registration and eligibility for a student between the ages of 19 and 26 for re-enrollment after a period of non-coverage.

10. **Totally Disabled Child**. A Subscriber shall be entitled to apply for continuation of coverage of a natural child, legally adopted child or stepchild after age nineteen (19) if the child is physically or mentally disabled, lives with the Subscriber or is institutionalized and is primarily dependent on the Subscriber for support and maintenance.

A. **Application Period**. The Subscriber must apply for continuation of coverage no later than 90 days following the child's nineteenth birthday or loss of continuous coverage as a full-time student under

this Plan. If the Subscriber fails to apply for continued coverage within ninety (90) days of the nineteenth (19th) birthday, eligibility for coverage is limited to the conditions outlined for full-time students or extended beneficiaries. If, however, the dependent child was eligible for coverage under the SHBP as a disabled dependent upon reaching age nineteen (19), a Subscriber shall be entitled to apply to enroll the disabled dependent upon loss of other group plan coverage, provided the application is filed with the SHBP no later than ninety (90) days following loss of other group plan coverage or loss of continuous coverage as a full-time student under this Plan.

B. **Documentation and Approval**. The Administrator shall require documentation as necessary to provide certification that the child is physically or mentally incapable of sustaining, self-supporting employment because of the physical or mental disability and that the child lives at the Subscriber'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 12 months or at the end of the projected disability period if that date is less than 12 months.

11. **Surviving Beneficiary**. A Subscriber's surviving beneficiaries, spouse and eligible dependent children, who were included in the coverage by the Employee or Retired Employee may continue coverage provided an application for continuing coverage is received within ninety (90) days following coverage termination as a result of the death of the Subscriber and one or more of the following conditions are met:

A. The surviving spouse of an active Employee may continue coverage provided the spouse is eligible to immediately receive a monthly benefit payment from a state supported retirement system in an amount sufficient to pay the premium. The spouse may elect coverage as a surviving spouse or as a Subscriber as a result of the spouse's own employment, but cannot elect double or dual coverage under separate provisions of the SHBP. The surviving spouse may elect to continue coverage for surviving eligible dependent children. Note an election to take a lump sum distribution rather than the monthly annuity negates eligibility to continue coverage as a surviving spouse.

B. The surviving spouse of a Retired Employee may continue coverage provided the spouse is eligible to immediately receive a monthly benefit payment from a state supported retirement system in amount sufficient to pay the premium. The spouse may elect coverage as a surviving spouse or as a Subscriber as a result of the spouse's own employment, but cannot elect double or dual coverage under separate provisions of the SHBP. The surviving spouse may elect to continue coverage for surviving eligible dependent children. Eligibility to continue dependent children shall terminate in accordance with provisions for dependent children.

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

E. The surviving spouse 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. The surviving spouse of a Retired Employee who is included in coverage at the time of death of the Subscriber 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 Subscriber's dependent children at the time of the Subscriber's death under the following conditions:

(1) The surviving spouse must make written application no later than ninety (90) days following coverage termination as a result of the death of the Retired Subscriber, and.

(2) The parties must have been married at least one full year prior to the death of the Retired Subscriber, and

(3) The surviving spouse agrees to pay the quarterly premium payment established by the Board in accordance with the established requirements, and

(4) Coverage under this provision shall terminate for the surviving spouse and any enrolled dependent children in the event the surviving spouse remarries.

12. **Retired Employees Having Intermittent Periods of Active Employment**. Retired Employees who are eligible to continue coverage under these regulations may elect to return to or continue active service with any of the Employing Entities. In such case, the retirement benefit may be suspended or continued; however, the health benefit coverage must be purchased as an active Employee. At the point the Employee discontinues active service and returns to retired status, health benefit coverage may be, upon notification to the Plan, reinstated with continuous 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 group of Employees to be entitled to enroll as a Retiree, unless the final active service period qualifies the Employee for a retirement benefit by one of the state supported retirement systems.

13. **Judicial Reinstatement of State Employees**. State Employees who are reinstated to employment by the State Personnel Board or the judiciary shall have coverage reinstated for themselves and any eligible dependents. If employment reinstatement occurs within twelve (12) months of discharge and back-pay for continuous employment is awarded, all retroactive premiums must be collected and claims incurred during the period may be filed for processing. If back-pay to provide for continuous employment is not awarded, coverage may be reinstated with the Subscriber's return to work. If reinstatement occurs following a period longer than twelve (12) months after the discharge, coverage for Subscriber and previously Covered Dependents will be reinstated when the Subscriber 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 thirty-one (31) days after reinstatement to modify coverage in compliance with open enrollment guidelines. Pre-existing condition limitations will be waived for the reinstatedSubscriber and all previously enrolled dependents. Employing Entities shall be responsible for collecting any premiums due for the selected coverage.

14. **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. §§ 45-18-1 *et seq.*, 45-20-2, 47-2-313, 47-6-41, 31-3-2.1, 20-2-895, 20-2-880, 20-2-880(4), 20-2-910(3), 20-2-885, 20-2-915, 20-2-887, 20-2-881, 20-2-911, 20-2-912, 20-2.886, 20-2.916, 20-2.55, 20-2-923, Family and Medical Leave Act of 1993 (FMLA), Social Security Act, Uniformed Services Employment & Reemployment Act.

SYNOPSIS

Rule 111-4-1.05
(formerly 478-6.05)

STATEMENT OF PURPOSE AND MAIN FEATURES OF PROPOSED RULE

The proposed amendment modifies the existing regulation in light of changes in the governing statute(s), specifically changes made by Ga. L. 1999, p. 296, § 1, enacted at the 1999 session of the General Assembly, which created the Department of Community Health and transferred the responsibility for administration of the law governing the State Health Benefit Plan to that agency.

DIFFERENCES BETWEEN EXISTING AND PROPOSED RULES

The existing regulation, 478-6.05, is repealed and reenacted as 111-4-1.05, as modified, with the rules and regulations of the Department of Community Health.

Cites within the text have been corrected to reflect the new rule numbers.

Grammatical errors and errors in capitalization have been corrected.

Headings have been bolded for ease of identification of subsections.

Dates at the end of each subsection reflecting the updated changes to the regulations have been removed.

Any citation to authority at the end of a subsection has been removed and listed at the end of this section of the regulations.

The term “Coverage Tier” or “Tier” has replaced the term “Coverage Type” to indicate the type of contract offered to a Subscriber.

Language in 111-4-1.05 subsection 4 has been changed to indicate that the effective date for re-enrollment for coverage following a leave of absence without pay shall be the first of the month following return to work.

Language in 111-4-1.05 subsection 4 has been changed to indicate that the effective date for re-enrollment for coverage following Military Leave or Military Reservist Activation Leave without pay shall be the first of the month following return to work.

Language in 111-4-1.05 subsection 5E has been changed to clarify that the effective date of coverage for adopted children cannot be earlier than the date of placement specified in the adoption contract.

478-6.05 REPEALED.

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 Employee 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 Tier to add eligible dependents shall be July 1st unless employment terminated on or before that date.

4. **Upon Return from Leave Without Pay**. The effective date for re-enrollments following a leave 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 Leave or Military Reservist Activation Leave 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 Employee 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 date of marriage to the Employee.

   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.

   C. **Natural Children**. The effective date of coverage shall be the date of birth.

   D. **Stepchildren**. The effective date of coverage shall be no earlier than the date of marriage of the Employee and the natural parent of the children or the date that the stepchildren began living in the home of the Employee, if later than the date of parental marriage.

   E. **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. **Other Children**: The effective date of coverage shall be the first of the month in which the court approves legal guardianship.

Authority: O.C.G.A. §§45-18-2, 20-2-881, 20-2-911 HIPAA, Internal Revenue Code Section 125, Uniformed Services Employment and Reemployment Act 5.

SYNOPSIS

Rule 111-4-1.06
(formerly 478-6.06)

STATEMENT OF PURPOSE AND MAIN FEATURES OF PROPOSED RULE

The proposed amendment modifies the existing regulation in light of changes in the governing statute(s), specifically changes made by Ga. L. 1999, p. 296, § 1, enacted at the 1999 session of the General Assembly, which created the Department of Community Health and transferred the responsibility for administration of the law governing the State Health Benefit Plan to that agency.

DIFFERENCES BETWEEN EXISTING AND PROPOSED RULES

The existing regulation, 478-6.06, is repealed and reenacted as 111-4-1.06, as modified, with the rules and regulations of the Department of Community Health.

Cites within the text have been corrected to reflect the new rule numbers.

Grammatical errors and errors in capitalization have been corrected.

Headings have been bolded for ease of identification of subsections.

Dates at the end of each subsection reflecting the updated changes to the regulations have been removed.

Any citation to authority at the end of a subsection has been removed and listed at the end of this section of the regulations.

All references to Plan members, Employees, or Retirees when referencing covered individuals under the State Health Benefit Plan are removed and replaced with the term “Subscriber” to reflect contract holders of the Plan.

Language in 111-4-1.06 subsection 1 has been added to clarify that the Commissioner shall announce the dates for the Open Enrollment period annually.

The word “members” in 111-4-1.06 subsection 1 has been deleted and the words “Eligible Employees, Retirees and Extended Beneficiaries” have been added in its place inasmuch as these categories of persons may elect coverage under the Plan during Open Enrollment.

Reference to the Family Medical Leave Act has been deleted from the body of text in 111-4-1.06 subsection 1A and instead has been cited as statutory authority at the end of this section of the regulations.

The term “Coverage Tier” or “Tier” has replaced the term “Coverage Type” to indicate the type of contract offered to a Subscriber and is so used throughout this section.

The word “eligible” is added immediately preceding the word “Employee” in 111-4-1.06 subsection 5B to indicate that only eligible Employees who acquire a dependent may change Coverage Tier.

The word “Extended Beneficiary” is deleted from 111-4-1.06 subsection 5C as the reference to COBRA coverage is sufficient.

Language has been added to the end of 111-4-1.06 subsection 5D stating that the Plan will not provide a refund of premiums.

The term “Extended Coverage” is deleted from 111-4-1.06 subsection 5E and instead section 111-4-1.08 is referenced and the words “Effective Date of Coverage” are deleted and instead section 111-4-1.05 is referenced.

The word “discontinuation” is inserted in 111-4-1.06 subsection 5F to indicate that discontinuation of coverage will be no earlier than the date the Subscriber and SHBP enrolled dependent are covered under another plan.

Language is revised in 111-4-1.06 subsection 4G to indicate that Subscribers who fail to document dependent status will not be allowed to change Coverage Iier until the next Open Enrollment period and additional language is added as notification that the Plan will not refund premiums following a Coverage Tier change from family to single coverage.

Language is added in 111-4-1.06 subsection 4H requiring that notification of an alternate parent or Employing Entity of the Plan’s enrollment of a dependent in compliance with a Qualified Medical Child Support Order (QMCSO) will be dependent upon the directive of the order.

Language is added in 111-4-1.06 subsection 4H requiring that a Subscriber must produce a court order rescinding the QMCSO or proof that the Subscriber provides coverage for the child under other health insurance before the Plan will discontinue coverage.

The term “enrolled dependent” is changed to the defined term “Covered Dependent” in 111-4-1.06 subsection 4K as defined in 111-4-1.01 subsection 20.

Language in 111-4-1.06 subsection 4K is changed to indicate that a Covered Dependent must be enrolled in Medicare or Medicaid before a Subscriber changes to single coverage due to eligibility for Medicare or Medicaid.

Language in 111-4-1.06 subsection 4K is changed to indicate that a Subscriber enrolled in single Coverage Tier may discontinue coverage within 31 days of becoming enrolled in Medicare or Medicaid.

The word “members” has been changed to “Eligible Employees” in 111-4-1.06 subsection 4M as the term encompasses those persons entitled to enroll in the Plan.

The words “enroll” and “group plan” have been inserted in 111-4-1.06 subsection 4M in reference to allowing a Subscriber to either enroll, change to single Tier, or discontinue coverage when a Subscriber’s spouse has an open enrollment change in coverage under another employer’s cafeteria or

other qualified benefit plan that creates an overlap or gap in health coverage as a result of that group plan having a different plan year.

Language in 111-4-1.06 subsection 6A1 has been changed to reflect that a Subscriber except as provided in Section 111-4-1.06 subsection 7, may change to or from an HMO when the Subscriber no

longer resides or works within the HMO's approved geographic area and upon approval by the Administrator as SHBP operational rules have changed.

The provision allowing the Board discretion in determining if a significant hardship exists after a premium increase occurs has been deleted as SHBP operational rules have changed.

The word "PPO" is changed to "PPO Basic" in 111-4-1.06 subsection 6A4 as the name of the Plan Option has changed.

The word "PPO" is changed to "PPO Basic" in 111-4-1.06 subsection 6A5 as the name of the Plan Option has changed.

Language is added to 111-4-1.06 subsection 6B(2) to clarify that retirement systems must be state supported for a Retiree desiring to make an Option change.

Language is added in 111-4-1.06 subsection 6B(3) to clarify that a retired Subscriber must already be enrolled in Medicare before making an Option change.

Language has been added in 111-4-1.06 subsection 7 to clarify that a Subscriber may discontinue coverage when he or she acquires new coverage under the spouse's employer plan.

478-6.06 REPEALED.

111-4-1.06 CHANGES IN COVERAGE AND OPTION.

1. **Open Enrollment Period and Retiree Option Change Period**. The Open Enrollment Period and the Retiree Option Change Period shall be a minimum period of fifteen (15) days each year and shall begin no earlier than April 15 and shall end no later than 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 coverage as reflected in the following paragraphs.

   A. **Active Employees**. Eligible active Employees, eligible Employees on approved leave of absence and Extended Beneficiaries shall be given an opportunity to enroll or change Coverage Tier and Options during the Open Enrollment Period.

   B. **Retirees**. During the Retiree Option Change Period, enrolled Retirees shall be given an opportunity to change 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 Employee shall be offered the opportunity to enroll or change type of coverage and Option within thirty-one (31) days of the date the Employee returns to work.

3. **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 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. **Coverage Changes Other Than Open Enrollment or Retiree Option Change Period**. A Subscriber shall be eligible to change Tier coverage as outlined in these regulations. Requests to change or discontinue coverage must be filed no later than thirty-one (31) days following the qualifying event, unless otherwise noted in the specific provision. The effective date of the change or discontinuation shall be the first of the month following receipt of the request, unless otherwise noted in these provisions.

   A. **Marriage Resulting in Dual Coverage**. When a Subscriber marries and becomes eligible through the new spouse's employment, the Subscriber may discontinue coverage or change to single coverage, provided that all enrolled persons under the 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.

   B. **Acquisition of a Dependent**. When the Subscriber acquires a dependent through marriage, birth, or adoption, 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 Subscriber's eligible dependent child assumes or resumes full-time student status, the acquisition of a dependent definition is fulfilled

C. **Loss of Other Coverage**. When a Subscriber or Subscriber's spouse loses coverage through employment, a change to "family" Coverage Tier is permissible. Loss of the other coverage can be the Subscriber's, spouse's or ex-spouse's change in employment status affecting eligibility for health coverage under a cafeteria or other qualified health benefit plan, the ex-spouse's refusal to continue coverage on the dependent children, an approved leave of absence without pay by the spouse or ex-spouse resulting in termination of coverage or no employer's contribution to the premium, or the termination of the Subscriber's, spouse's or ex-spouse's group plan by his/her employer, or the termination of COBRA coverage. The Administrator shall require documentation to substantiate the loss of coverage.

D. **Loss of Dependent**. When a Subscriber loses all dependents through divorce, death, legal separation, or an only dependent no longer meeting 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. Loss of all dependents also applies when a 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 Subscribers' 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 change.

E. **Birth of Dependent**. A Subscriber, except as provided in Section 111-4-1.08, may change from "single" to "family" Coverage Tier within thirty-one (31) days following the birth of the child. 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. Coverage effective dates for the dependent(s) are established in accordance with Section 111-4-1.05

F. **Change in Employment Status**. An active Employee may change to single Coverage Tier or discontinue coverage when the spouse's or only enrolled dependent's employment status changes and affects the individual's eligibility under a cafeteria plan or other qualified health benefit plan. The application for change or discontinuance must be filed no later than thirty-one (31) days following the date that theSubscriber, spouse, or dependent first becomes eligible for coverage. The Administrator shall require documentation of the coverage under the other group health plan. Change Coverage Tier or discontinuation shall be approved no earlier than the date that the Subscriber and SHBP enrolled dependents are covered under the other group plan.

G. **Dependent(s) Eligibility Cannot Be Documented**. Subscribers having dependents whose eligibility cannot be documented will not be allowed to reduce their Coverage Tier until the next Open Enrollment Period unless a subsequent qualifying event occurs. No refund of premiums will be allowed for this change.

H. **Qualified Medical Child Support Order (QMCSO)**. A Subscriber will be enrolled or changed to "family" Coverage Tier upon determination by the Administrator that a court or

administrative order, judgment or decree is a qualified medical child support order for a natural child of a Subscriber. The Administrator shall notify the 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 law for processing the enrollment or change of coverage action. Enrollment or a change to family Coverage Tier under this paragraph shall not be subject to any timely filing requirements. A 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 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 Subscriber or alternate Subscriber who is the recipient of the QMCSO. , (12-18-96/1-1-97) (3-14-01) (10-1-04)

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

J. **Retired Employees**. Married Retired Subscribers may change coverage from family to each having single Coverage Tier at any time. The change in coverage will be effective within two (2) months following the Administrator's notice of the requested change.

K. **Eligible for Medicare or Medicaid**. Subscribers may change to single Coverage Tier within 31 days of all Covered Dependents becoming enrolled in Medicare or Medicaid coverage. Subscribers enrolled in singleTier may discontinue coverage within 31 days of becoming enrolled in Medicare or Medicaid coverage.

L. **Change to Family at Time of Involuntary Separation**. When a Subscriber is involuntarily separated, a change to familyCoverage Tier is allowed at the time of retirement, provided the Subscriber will immediately begin drawing a monthly benefit. The Administrator shall require documentation to substantiate the involuntary separation.

M. **Spouse's Open Enrollment Change**. Eligible Employees may enroll, change to single Tier or discontinue coverage when the Subscriber's spouse makes an open enrollment change in coverage under an employer provided cafeteria or other qualified benefit plan that creates an overlap or gap in health coverage as a result of the other group plan coverage having a different plan year. The effective date of the enrollment, 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.

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.

A. **Health Maintenance Organization Options (HMO)**. A Subscriber, except as provided for in Section 111-4-1.06 subsection 7, may change to, among, or from an HMO when:

(1) The Subscriber no longer resides or works within the HMO's approved geographic area and upon approval by the Administrator.

(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;

(3) The HMO ceases its operation for any reason, substantially decreases the number of medical care providers available, or ceases offering a Medicare+Choice managed care Option in the geographic area. In such case, the Employing Entity or Administrator shall automatically change the Employee's Option to the PPO Basic Option, unless the Subscriber discontinues coverage or chooses another Option for which the Subscriber is eligible within thirty-one (31) days of the occurrence;

(4) The Centers for Medicare & Medicaid Services cancels a Subscriber's coverage in a Medicare+Choice Option. In such case, the Administrator shall change the Subscriber's coverage to PPO Basic Option unless the Subscriber chooses another Option for which the Subscriber is eligible within thirty-one (31) days of the occurrence.

B. **Option Changes for Retirees**. dA Subscriber may change to any Option to which the Subscriber is eligible upon occurrence of one or more of the following events, provided the selection form is filed with the Administrator within 31 days following the event: (1) At the time of retirement

(2) At the time that the annuity amount to be received from a state supported retirement system becomes insufficient to satisfy the Option premium; or

(3) At the time that the Retired 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 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 of 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.

Authority: 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 of 1996 (HIPAA), Child Support Performance and Incentive Act of 1998, U.S.E.R.R.A.

SYNOPSIS

Rule 111-4-1.07
(formerly 478-6.07)

STATEMENT OF PURPOSE AND MAIN FEATURES OF PROPOSED RULE

The proposed amendment modifies the existing regulation in light of changes in the governing statute(s), specifically changes made by Ga. L. 1999, p. 296, § 1, enacted at the 1999 session of the General Assembly, which created the Department of Community Health and transferred the responsibility for administration of the law governing the State Health Benefit Plan to that agency.

DIFFERENCES BETWEEN EXISTING AND PROPOSED RULES

The existing regulation, 478-6.07, is repealed and reenacted as 111-4-1.07, as modified, with the rules and regulations of the Department of Community Health.

Cites within the text have been corrected to reflect the new rule numbers.

Dates at the end of each subsection reflecting the updated changes to the regulations have been removed.

Any citation to authority at the end of a subsection has been removed and listed at the end of this section of the regulations

Grammatical errors and errors in capitalization have been corrected.

Headings have been bolded for ease of identification of subsections.

All references to Plan members or Employees when referencing covered individuals under the State Health Benefit Plan are removed and replaced with the term “Subscriber” to reflect contract holders of the Plan.

The term “Coverage Tier” has replaced the term “Coverage Type” to indicate the type of contract offered to a Subscriber.

Language has been added to 111-4-1.07 subsection 1B to indicate that a Plan criterion for extended coverage under state law for a member of the General Assembly is that the General Assembly member does not withdraw Employee contributions from the public retirement systems.

Language is added in 111-4-1.07 subsection 1E to provide for the inclusion of processing and administrative fees when applicable for continuation coverage.

The first portion of the provision on extended coverage for teachers has been moved to 111-4-1.07 subsection 1C due to restructuring for ease of reading and the latter portion has been deleted due to a change in Plan operations.

Text entitled “Surviving Spouse” that references the former section 478-04(1)(b) is deleted as it is no longer applicable inasmuch as this class of individuals no longer exists.

The subsections entitled “Retiree Not Eligible to Receive Sufficient Retirement Benefit to Pay the Deduction Amount” and “Retiree No Longer Receiving Sufficient Retirement Benefit” have been combined as the substance overlaps and the meanings are duplicative.

Section 111-4-1.07 subsection 4A-4C has been deleted as this was a one time special enrollment period and is no longer applicable to Plan operations.

478-6.07 REPEALED.

111-4-1.07 EXTENDED COVERAGE UNDER STATE LAW.

1. **Employee**. Employees are permitted to continue Coverage Option and Tier under conditions outlined by State Law. Application for Extended Coverage must be made to the Administrator within sixty (60) days following coverage termination as an active Employee or Extended Beneficiary. Coverage election under Section111-4-1.08, 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.

   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 Section111.4-1.04(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 the period required for the State Personnel Board to render a decision but no longer than six (6) 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 Subscriber and the Administrator of the Subscriber's eligibility to continue coverage. Failure to pay the premium within the allotted time shall forfeit 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 Subscriber 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 Subscriber fails to pay the required premium billed by the Administrator within 30 days following receipt of a premium notice or the Subscriber withdraws Employee contributions from the respective retirement system. Failure to pay the premium within the allotted time shall forfeit 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 public school Employee as defined in Section111.4-1.04(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

coverage. Prior to December 1, 1986, a public school 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 coverage by making application to the Administrator; provided that coverage shall not become effective earlier than the first of the month in which the application for coverage was received by the Administrator.

E. **Required Premiums**. Except as noted in subparagraph A2 and (B) , premiums for continuing coverage under this provision shall be billed to the Subscriber monthly in an amount equal to the total cost for coverage, which is the Employee's share and the employer's cost for benefits and administration, plus processing and administrative fees where applicable. Failure to pay the premium within the allotted time shall forfeit eligibility for continued coverage.

F. **Notice**. The Administrator shall include a notice of payment requirements and penalties on application forms for continued coverages.

2. **Pending Retiree**. An active 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 coverage during the period between termination of coverage as an active Employee and the effective date of coverage 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.

A. **Coverage as a pending Retiree** must be based on a reasonable expectation that the active 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) 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 pending Retiree shall be inclusive of Extended Coverage 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 coverage under this provision. Any coverage under this provision is inclusive of the maximum length of time allowed under the Extended Beneficiary 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, coverage may be reinstated as a Retiree. Coverage reinstatement is allowed if the Retiree requests reinstatement within sixty (60) days following the reversal of the retirement system's decision. Reinstatement shall be effective as soon as administrative processes for deduction are completed, but no later than sixty (60) days following notification to the Administrator. The Retiree and dependents who were enrolled in the Plan will be reinstated without regard to the pre-existing condition 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) 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 s the Employee deduction rate plus a processing fee and shall be paid monthly.

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 premium amount by payroll deduction, the Retiree shall be permitted to continue coverage by paying a quarterly premium as set by the Board. The premium rate shall be the same as the Retiree deduction rate plus a processing fee.

4

Authority: O.C.G.A. §§45-18-1 *et seq.* , 20-2-888, 20-2-915, 20-2-915.1.

SYNOPSIS

Rule 111-4-1.08
(formerly 478-6.08)

STATEMENT OF PURPOSE AND MAIN FEATURES OF PROPOSED RULE

The proposed amendment modifies the existing regulation in light of changes in the governing statute(s), specifically changes made by Ga. L. 1999, p. 296, § 1, enacted at the 1999 session of the General Assembly, which created the Department of Community Health and transferred the responsibility for administration of the law governing the State Health Benefit Plan to that agency.

DIFFERENCES BETWEEN EXISTING AND PROPOSED RULES

The existing regulation, 478-6.08, is repealed and reenacted as 111-4-1.08, as modified, with the rules and regulations of the Department of Community Health.

Cites within the text have been corrected to reflect the new rule numbers.

Dates at the end of each subsection reflecting the updated changes to the regulations have been removed.

Citation to the appropriate legal authority has been listed at the end of this section of the regulations.

Grammatical errors and errors in capitalization have been corrected.

Headings have been bolded for ease of identification of subsections.

The term “Coverage Tier” or “Tier” has replaced the term “Coverage Type” to indicate the type of contract offered to a Subscriber.

The word “deceased” is added in 111-4-1.08 subsection 1D to clarify that extended coverage for the eligible spouse of a deceased Employee begins on the first of the month following termination of coverage through the deceased employee Employee’s payroll deduction.

The word “deceased” is added in 111-4-1.08 subsection 1E to clarify that extended coverage for the eligible dependent child of a deceased Employee begins on the first of the month following termination of coverage through the deceased Employee’s payroll deduction.

The word “document” is replaced with “Description” in 111-4-1.08 subsection 1M as it references the defined term Summary Plan Description as defined in 111-4-1.01 subsection 53.

The defined term “Subscriber” replaces the word “Employee” as the term references an individual covered under the State Health Benefit Plan who is a contract holder under the Plan.

Language in 111-4-1.08 subsection 1M2 is added to clarify that the Subscriber will have 60 days from the later of the qualifying event or termination of coverage as a result of the qualifying event to notify the Administrator.

The term “Extended Beneficiary” is added to 111-4-1.08 subsection 1M4 indicating that the Administrator shall notify the Extended Beneficiary of continuation rights at an address specified by the Extended Beneficiary.

478-6.08 REPEALED.

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 coverage in the enrolled Option, without evidence of insurability. An Extended Beneficiary shall have the same opportunities for enrolling eligible dependents and changing CoverageTiers and Options as active 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 Employee who terminates employment or is separated from his employment for any reason other than for gross misconduct, or whose approved leave without pay expires shall be eligible to continue coverage under the Plan for a period not longer than eighteen (18) months following the termination of coverage as an Employee.

B. **Reduction of Required Hours**. An Employee who continues SHBP eligibility under the definition of Employee, except for working the required number of hours, shall be eligible to continue coverage under the Plan for a period not longer than eighteen (18) 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) month period would begin on the first of the month following termination of coverage through payroll deductions.

C. **Laid-off Employee**. An Employee who is determined to be a laid-off Employee shall be eligible to continue 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 coverage through payroll deductions.

D. **Spouse of Deceased Employee**. The spouse of a deceased Employee who is not eligible as a surviving spouse, an Employee, or an annuitant shall be eligible to continue coverage for the spouse and any covered, eligible dependents under the Plan for a period not longer than thirty-six (36) months. The extended period of coverage begins on the first of the month following termination of coverage through the deceased Employee's payroll 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 dependent child of a deceased Employee who is not eligible as a dependent of another Employee, a surviving beneficiary under Section 111-4-1.6-.04(10), an Employee, or an annuitant shall be eligible to continue individual coverage under the Plan for a period not longer than thirty-six (36) months following the end of the month in which death occurred. Any months for which coverage was granted under Section 111-4-1.6-.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 coverage through payroll deductions.

F. **Dependent Child**. An eligible dependent child of an 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) 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 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) months for the spouse and any enrolled eligible 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) 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) 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) days following the date of the determination. Such notice must be given within the initial eighteen-month continuation period. Additionally, the Extended Beneficiary must notify the Administrator within thirty (30) days of the date of any final determination that the beneficiary is no longer disabled. The Administrator is authorized to charge 150% of the applicable premium as outlined under Section 111-4-1.08 (l).

I. **Multiple qualifying events**. If additional qualifying events occur which provide for a thirty-six (36) 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) months for a 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 Option shall include the total employer and Employee cost plus 2% of the total premium cost as established by the Board for Employees with eligibility under Section111-4-1.6-.08(1), except that the Extended Beneficiary shall pay this premium on a monthly basis. An additional 48% of the total premium/cost for any 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.

M. **Notice Requirements**. At the time of implementation of the Extended Beneficiary provisions, the Administrator shall distribute to the Employing Entities, having active 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 reduced hours within thirty (30) days following the event.

(2) The Subscriber 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) days of the later of the of the qualifying event or termination of coverage as a result of the qualifying event. Failure to notify the Administrator within the sixty (60) 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) days following notification from the Employing Entity of the Employee's death, termination of employment, or reduction of hours. Notice to the Employee's spouse 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) days following notification from the Employee of a divorce, legal separation, or the dependent child's coverage ineligibility as a dependent.

(5) 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 payment 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) days following the Administrator's notification to the Extended Beneficiary or the sixty (60) 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) 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, spouse, dependent, or annuitant. If a beneficiary, either the Employee or spouse of a covered 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 111-4-1.6-.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 employeeor 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).

SYNOPSIS

Rule 111-4-1.09
(formerly 478-6.09)

STATEMENT OF PURPOSE AND MAIN FEATURES OF PROPOSED RULE

The proposed amendment modifies the existing regulation in light of changes in the governing statute(s), specifically changes made by Ga. L. 1999, p. 296, § 1, enacted at the 1999 session of the General Assembly, which created the Department of Community Health and transferred the responsibility for administration of the law governing the State Health Benefit Plan to that agency.

DIFFERENCES BETWEEN EXISTING AND PROPOSED RULES

The existing regulation, 478-6.09, is repealed and reenacted as 111-4-1.09, as modified, with the rules and regulations of the Department of Community Health.

Cites within the text have been corrected to reflect the new rule numbers.

Dates at the end of each subsection reflecting the updated changes to the regulations have been removed.

Any citation to authority at the end of a subsection has been removed and listed at the end of this section of the regulations.

Grammatical errors and errors in capitalization have been corrected.

Headings have been bolded for ease of identification of subsections.

References to employees when referring to individuals covered under the State Health Benefit Plan are removed and replaced with the term “Subscriber” to reflect contract holders of the Plan.

The phrase “except layoff, approved leave without pay, transfer or retirement” is deleted from 111-4-1.09 subsection 1 due to a change in Plan operations.

The hours in 111-4-1.09 subsection 3B have been changed from eighteen to seventeen and one-half for statutory compliance.

The allowance for an earlier termination date for dependent coverage as a result of a QMCSO or other court orders that specify an expiration date is added to 111-4-1.09 subsection 6.

Language is added in 111-4-1 subsection 7B to allow continuation of coverage for a child’s nonattendance at an accredited school for two successive semesters provided the intent is to return during the fourth semester.

The phrase “by the Employee” has been deleted and the word “coverage” has been inserted in 111-4-1.09 subsection 8 in an effort to clarify that an Employee declines eligibility to continue coverage by a failure to remit premiums timely.

Language is added in 111-4-1.09 subsection 10 clarifying health coverage will terminate at the end of the month following the determination that a Subscriber is not eligible to receive an annuity under a state supported retirement system.

Language is added in 111-4-1.09 subsection 11C to clarify that health benefit coverage for Extended Beneficiaries will terminate at the end of the month that the beneficiary is actually enrolled in Medicare.

111-4-1.09 subsection 11E is added allowing for expiration of Extended Beneficiary coverage upon cancellation of a contract with whom the Board of Community Health contracts.

111-4-1.09 subsection 12 is added detailing termination of coverage for a deceased Subscriber.

111-4-1.09 subsection 14 has been added to indicate that coverage may be discontinued when an Employing Entity fails to remit premiums in a timely manner.

478-6.09 REPEALED.

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 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 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.

   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.

   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; however, the sixty (60) percent cannot be less than 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 Without Pay**. If a Subscriber on an approved leave without pay fails to return to active employment, coverage will terminate at the earlier of the end of the month for which the leave 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 leave 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 dependent 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 coverage 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 full-time student shall terminate at the earlier of the end of the month in which the dependent child graduates, or

A. At the end of the month in which academic requirements for graduation are completed if graduation is delayed more than one month, or

B. At the end of the month in which the child ceases to be in full-time attendance 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 coverage on a prospective basis when information becomes available that the child no longer fulfills the requirements of a full-time student.

8. **Failure to Remit Premium**. Failure to remit the billed premium amount within thirty (30) days following the end of the month for which coverage has been paid will constitute forfeiture of eligibility to continue coverage while on leave without pay or ExtendedCoverages of any kind. Coverage will not be reinstated for payments received thirty (30) days following termination of coverage for insufficient payment, unless an administrative error has been made. Failure to remit premium will constitute a declination of eligibility to continue coverage as an Extended Beneficiary without further notice by the Administrator. .

9. **Expiration of Approved Leave of Absence Without Pay**. Coverage will terminate at the end of the month following expiration of the approved leave 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 coverage will terminate at the end of the month following determination that the Subscriber is not immediately eligible to receive an annuity under a state supported retirement system operated Employee, unless the Subscriber is eligible to continue coverage 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 coverage for extended beneficiaries will terminate at the end of the month in which the earliest of the following conditions occur:

A. The premium is not paid within the time allowed under these regulations;

B. The maximum 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**. Coverage shall terminate no later than the end of the month of death of a Subscriber enrolled in single Tier coverage. Coverage shall terminate no later than the end of the month following the month of death of a Subscriber enrolled in family Tier. The Employing Entity, retirement system or deceased's estate shall remit the appropriate premium. A surviving beneficiary may continue coverage as outlined in 111-4-1.04 (11).

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 coverage outside the annual Open Enrollment period. Documentation of other coverage may be required. Requests to discontinue coverage must be approved by the Administrator.

14. **Suspension of Benefits due to Nonpayment**. If an Employing Entity fails to submit premiums or documentation or fails to reconcile bills in a proper and timely manner, the Plan may suspend benefit payments.

Authority: O.C.G.A. §§45-18-1 *et seq.*, 20-2-881, 20-2-911, IRS Code Section 125

SYNOPSIS

Rule 111-4-1.10
(formerly 478-6.10)

STATEMENT OF PURPOSE AND MAIN FEATURES OF PROPOSED RULE

The proposed amendment modifies the existing regulation in light of changes in the governing statute(s), specifically changes made by Ga. L. 1999, p. 296, § 1, enacted at the 1999 session of the General Assembly, which created the Department of Community Health and transferred the responsibility for administration of the law governing the State Health Benefit Plan to that agency.

DIFFERENCES BETWEEN EXISTING AND PROPOSED RULES

The existing regulation, 478-6.10, is repealed and reenacted as 111-4-1.10, as modified, with the rules and regulations of the Department of Community Health.

Any citation to authority at the end of a subsection has been removed and listed at the end of this section of the regulations.

Dates at the end of each subsection reflecting the updated changes to the regulations have been removed.

Cites within the text have been corrected to reflect the new rule numbers.

Grammatical errors and errors in capitalization have been corrected.

Headings have been bolded for ease of identification of subsections.

The term “health maintenance organization” is replaced with the acronym “HMO” in 111-4-1.10 subsection 1.

Benefit schedule approvals listed in 111-4-1.10 subsections 1A(1)-(16) have been restructured for ease of reading.

Section 111-4-1.10 subsections 1A(17) – (28) have been added to include additional approved benefit changes, as legislation requires that a benefit schedule be included in the Department of Community Health regulations.

The term “Summary Plan Description” replaces the term “Plan booklet” in 111-4-1.10 subsections1B, 1F and also later in this section of the regulations in 111-4-1.10 subsection 5.

Section 111-4-1.10 subsections (k)1-2 have been deleted as SHBP operational rules have changed.

Language has been added in Section 111-4-1.10 subsection 4B to reflect that notification will be sent to SHBP vendors to facilitate processing of claims as a primary payor.

The words “entitled to” have been replaced with the words “eligible for” in reference to ineligibility for Medicare Parts A and B in 111-4-1.10 subsection 4E.

Language has been added in Section 111-4-1.10 subsection 5D to allow an exception for coverage of wellness/preventive benefits.

The word “agents” has been deleted from 111-4-1.10 subsection 6, as it is not applicable.

478-6.10 REPEALED.

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. *, 45-18-2, 20-2-881, 20-2-911, 20-2-913*

   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 6/1/89; 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, modify the notification time for compliance with utilization review processes effective July 1, 1993, 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.

(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;

(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;

(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;

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

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

(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;

(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/Preventative 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;

(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;

(26) **December 12, 2001** (verify date). 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;

(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;

(28) **March 10, 2004** Approval was given for the following: (a) 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. (b) 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.

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 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 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 or 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 establish procedures 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 to appeal an adverse determination of eligibility for coverage or of a benefit, service, or claim. These procedures shall

be outlined in the Summary Plan Description to advise the Subscriber of the process to initiate an appeal. However, the Administrator has the final authority for approval in accordance with the schedule of benefits and the interpretation thereof.

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 purchased 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.

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.

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) 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) 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 63 days;

(2) The Subscriber 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) days of the Subscriber'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) 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) days), but not for the SHBP waiting period (i.e., first full month before the effective date); and

B.If the Sbscriber 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 Subscriber 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) months. A new pre-existing condition requirement will not be applicable when coverage for all Subscribers of the family are transferred from one spouse to the other spouse or an enrolled dependent becomes covered as an Employee.

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

3. **Coordination of Benefits**. Coordination of Benefit provisions are intended to establish uniformity in the permissive use of over 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 Subscribership 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:

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

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

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

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

(d) 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.

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(4) When the active Subscriber 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 Subscriber or eligible dependents 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 dependent of the Retired Employee or surviving spouse of an Employee, the other plan will be primary.

D. When payment has been made by this Plan in excess of the maximum amount of payment necessary at that time to satisfy the intent of the Coordination of Benefit provision, the Plan shall have the right to recover the excess payments, payments greater than 100% of eligible and covered charges, from among the other insurers, the Subscriber 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 require such change.

A. Prior to the Subscriber reaching age sixty-five (65), the Administrator shall notify the Subscriber 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 Subscribers who are active and elect the SHBP as the primary payor, notification will be transmitted to the TPA and other vendors to facilitate processing future claims as the primary payor. The Administrator shall assume that the spouse, who is age sixty-five (65) or older, of a Subscriber who continues to work has chosen the SHBP as the primary payor, unless the Subscriber or his spouse otherwise notifies the Administrator.

C. When retired Subscribers or their eligible dependents are 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 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 Subscriber 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 of Medicare, the Subscriber’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 Subscribers who were not informed of the increased premium when the Subscriber was first eligible for Medicare enrollment or for Subscribers who are not eligible for Parts A and B 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 $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 benefits;

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

E. Charges for treatment specifically for dental or vision care;

F. Charges for treatment for experimental or investigative services or supplies;

G. Charges that are considered educational or treatment to restore learning capacity;

H. Charges in connection with custodial care, extended care facilities or a nursing home;

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

J. Charges in connection with therapy for learning disabilities;

K. Charges for prosthesis or equipment which are determined to be not medically necessary.

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

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

B. The Board of Community Health reserves the right to modify its benefits, coverages, and eligibility requirements at any time, subject only to reasonable advance notice to its Subscribers. 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 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.

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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 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 or eligible dependent is totally disabled, reimbursement for that individual's treatments for the condition that caused the disability shall continue for up to four (4) additional 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. (7-1-86)

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. §§45-18-1 *et seq.*, 20-2-881, 20-2-911, 20-2-912, 20-2-913, 20-2-882, 20-2-883, 20-2-914, 20-2-884, 20-2-887, 20-2-885, 20-2-915, Health Insurance Portability and Accountability Act of 1996 (HIPAA), Social Security Act.

SYNOPSIS

Rule 111-4-1.11
(formerly 478-6.11)

STATEMENT OF PURPOSE AND MAIN FEATURES OF PROPOSED RULE

The proposed amendment modifies the existing regulation in light of changes in the governing statute(s), specifically changes made by Ga. L. 1999, p. 296, § 1, enacted at the 1999 session of the General Assembly, which created the Department of Community Health and transferred the responsibility for administration of the law governing the State Health Benefit Plan to that agency.

DIFFERENCES BETWEEN EXISTING AND PROPOSED RULES

The existing regulation, 478-6.11, is repealed and reenacted as 111-4-1.11, as modified, with the rules and regulations of the Department of Community Health.

Dates at the end of each subsection reflecting the updated changes to the regulations have been removed.

Any citation to authority has been listed at the end of this section of the regulations.

Cites within the text have been corrected to reflect the new rule numbers.

Grammatical errors and errors in capitalization have been corrected.

Headings have been bolded for ease of identification of subsections.

All references to Plan members and Employees when referencing covered individuals under the State Health Benefit Plan are removed and replaced with the term “Subscriber” to reflect the contract holder of the Plan.

The words “Health Maintenance Organization” replaces the acronym “HMO” in the heading for section 111-4-1.11 subsection 1.

The defined term “Retiree” replaces the word “annuitant” in 111-4-1.11 subsection 2 and the words “eligible SHBP” are deleted inasmuch as they are redundant when read in context with the remainder of the provision.

The subsection entitled “Qualified HMO” is deleted as it is outdated and the Plan now offers self-funded HMO plans that do not operate under this definition.

The definition of “Service Area” for an HMO is deleted inasmuch as it falls under the general definition for “Service Area” defined in 111-4-1.11 subsection 49 of these regulations.

The heading entitled “Procurement of HMOs” replaces the heading “Proposal from an HMO” in the heading for section 111-4-1.11 subsection 4 as the word “procurement” is the appropriate term for the

process. Language in the provision has been modified to reflect the current procurement process for HMOs.

The word “requirements” replaces the word “information” in 111-4-1.11 subsection 6A to reflect consistency with the Plan’s current procurement process.

The heading “Inclusion in the Health Benefit Plan” and all accompanying subsections under that heading, with the exception of subsection D, have been deleted inasmuch as the information contained in those provisions is outdated and is no longer operational. The information in subsection D now falls under 111-4-1.11 subsection 7, which has been given the heading “HMO Eligibility.”

The words “another” and “the” are inserted in 111-4-1.11 subsection 12 in order to add clarity to the intent of the provision.

The word “Option” is added to 111-4-1.11 subsection 13 referencing the Retiree Option Change Period.

The heading entitled “Employer Contributions to HMO” and all subsections thereunder have been deleted inasmuch as the provisions are outdated and are no longer operational under the Plan.

The heading entitled “Employer Contributions to HMO for Medicare Enrolled Retirees” and the accompanying text have been deleted inasmuch as the provision is outdated and is no longer operational under the Plan.

The heading entitled “Basis of Employer Contribution to HMO” and the accompanying text have been deleted inasmuch as the information is outdated and is no longer operational under the Plan.

The heading entitled “Employee or Retiree Deductions for HMO Option” and the accompanying text has been deleted inasmuch as the information is outdated and is no longer operational.

The words “PPO or Indemnity” have been replaced with the defined term “Regular Insurance” in 111-4-1.11 subsection 13 to add clarity to the intent of this provision.

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478-6.11 REPEALED.

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 300e) 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.

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 minimumrequirements specified by the Commissioner.

B. All proposals for inclusion shall be evaluated according to the criteria outlined in the Request for Proposal.

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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 111-4-1.6-.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 theRegular Insurance, the claim payments will be coordinated so that only 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 111-4-1.6-.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 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 will 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. §§45-18-2, 45-18-6, 20-2-881, 20-2-884, 20-2-911.

SYNOPSIS

Rule 111-4-1.12
(formerly 478-6.12)

STATEMENT OF PURPOSE AND MAIN FEATURES OF PROPOSED RULE

The proposed amendment modifies the existing regulation in light of changes in the governing statute(s), specifically changes made by Ga. L. 1999, p. 296, § 1, enacted at the 1999 session of the General Assembly, which created the Department of Community Health and transferred the responsibility for administration of the law governing the State Health Benefit Plan to that agency.

DIFFERENCES BETWEEN EXISTING AND PROPOSED RULES

The existing regulation, 478-6.12, is repealed and reenacted as 111-4-1.12, as modified, with the rules and regulations of the Department of Community Health.

Cites within the text have been corrected to reflect the new rule numbers.

Dates at the end of each subsection reflecting the updated changes to the regulations have been removed

Any citation to authority has been listed at the end of this section of the regulations.

Grammatical errors and errors in capitalization have been corrected.

Headings have been bolded for ease of identification of subsections.

All references to Plan members are removed and replaced with the term “Subscriber” to reflect contract holders of the Plan.

478-6.12 REPEALED.

111-4-112 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' and providers' use when appropriate.

2. **Liability Period**. All claims for benefits must be presented in writing to the Administrator or TPA within six (6) 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 months following the month of service. If any claim for benefits is presented to the Administrator or TPA after two 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) months of the date the draft was drawn. If the payee orSubscriber does not present the draft or request a reissue of the draft for a period of 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. §§45-18-2, 45-18-11, 20-2-881, 20-2-890, 20-2-911, 20-2-917.