SHBP
State Health Benefit Plan

STATE HEALTH BENEFIT PLAN

Employers Administrative Guide 2010

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NOTE: The purpose of these procedures is to provide a manual for administering the operational aspect of the State Health Benefit Plan (SHBP) consistent with the Board of Community Health regulations and policies. If an interpretative conflict between statements in these procedures and the Regulations occurs, the Regulations shall prevail.

OVERVIEW

The Georgia Department of Community Health (DCH) administers the State Health Benefit Plan (SHBP). The SHBP provides health coverage to more than 690,000 state employees, teachers, retirees and dependents. SHBP's eligibility rules are governed by United States (US) Code; Title 26, 125 (Section 125 of the Internal Revenue Code). This specific US Code speaks directly to cafeteria plans and their administration under Section 125. The SHBP is governed by the Regulations of the Department of Community Health Board, Chapter 111-4-1 Health Benefit Plan.

The purpose of this document is to serve as a user's guide for each payroll location to assist with administrating the operational aspect of the SHBP while remaining consistent with Section 125 of the Internal Revenue Code (Section 125), and DCH Regulations and policies. The SHBP reserves the right to modify the eligibility and/or participation requirements at any time, subject only to reasonable notification to members. When such change is made, it will apply as of the modification's effective date and after, unless otherwise specified by DCH. If an interpretative conflict between statements outlined in this document and the DCH Regulations occurs, the Regulations shall prevail.

SHBP FORMS

Introduction

The administration of the SHBP requires the use of a variety of forms. Forms are necessary for enrolling employees, changing coverage and various other updates to the Plan. All the SHBP forms have been designed to gather the appropriate information for the type of action being requested by the employee.

Employing Entity Responsibility

More than 800 employing entities are responsible for assisting their employees with completing the appropriate forms and submitting those forms to the SHBP on a timely basis. In order to assist the employees, the employing entities should be familiar with all the SHBP forms and maintain an adequate supply of all forms to meet the anticipated needs of their employees.

Online SHBP Forms Access

Although it is the employing entities responsibility to maintain an adequate supply of SHBP forms, as a convenience, SHBP has placed some forms online for easy access. These forms are available for printing at the DCH website, www.dch.georgia.gov/shbp. All SHBP forms contain an attestation statement.

SHBP Job Aid: SHBP Forms

Form Eligibility Function	Form Name and Form #	Additional Details
Appeals	Administrative Review Form (RS-101) and Formal Appeal Form (RS-100)	The Administrative Review form should be used after contacting Member Services and requesting a telephone review within 90 days of the eligibility denial. This form is used as the second level of appeal under the plan and must be filed within 90 days of the denied action concerning eligibility. The Formal Appeal Form is used if the Administrative Review is denied by SHBP
Over Age Dependent Coverage	Dependent Student Status Information (MSSTB1)	Use this form to update the status of a dependent child who is over the age of nineteen for coverage as a fulltime student... An update is required every twelve months if the member desires to keep a valid identification card showing the student as a covered dependent.
Surcharges Spousal and Tobacco	Spousal Surcharge Form (SP01)	Use this form to remove a spousal surcharge when spouse is not eligible is not enrolled for health coverage through their employer. This form must be returned to your Payroll Location Benefit Coordinator/Human Resource Representative.
	Non-Tobacco Cessation Affidavit Form (TC03)	Use this form to remove a tobacco surcharge. If you and all covered dependents are non-tobacco users. This form must be returned to your Payroll Location Benefit Coordinator/Human Resource Representative.
	Tobacco Cessation Affidavit Form (TC-2)	This form must be returned to your Payroll Location Benefit Coordinator/Human Resource Representative.
Decline or Discontinue Coverage	Declination or Health Benefit Coverage (66-004)	Use this form when an employee declines coverage upon employment or is ineligible for coverage due to employment status. (E.g. part-time employee). This form must be returned to your Payroll Location Benefit Coordinator/Human Resource Representative.
	Discontinuation of Health Benefit Coverage (66-089)	This form must be returned to your Payroll Location Benefit Coordinator/Human Resource Representative.

SHBP Job Aid: SHBP Forms

Form Eligibility Function	Form Name and Form #	Additional Details
Decline or Discontinue Coverage	Retiree Discontinuation Form (66-088)	Please contact the SHBP Call Center at 404-656-6322 or 1-800-610-1863 for further information. NOTE: If you discontinue you will NOT be eligible to re-enroll for any coverage under the State Health Benefit Plan.
	2010 EE Enrollment/Transfer Form (SHBP 66-091)	This form is to be used only for New employees hired or enrolling after 12/31/08. This form must be returned to your Payroll Location Benefit Coordinator/Human Resource Representative.
	Change and Miscellaneous Update Form (66-090)	Must be completed by each eligible employee who wishes to enroll or change coverage option or type in any option offered by the SHBP. The form must be returned to your Payroll Location Benefit Coordinator/Human Resource Representative.
	Retiring/Surviving Spouse Form (66-092)	This form should be used when a retiring member elects to continue coverage through retirement or to change option or type of coverage after retirement.
Employer Use Only	Forms Transmittal Sheet (66-010)	This form is used as a control document that should be placed on top of any forms submitted and for submitting any coverage terminations to the SHBP.
	Notification of Return from Leave Without Pay (66-093)	Use this form to notify the SHBP when a member returns to work after being on an approved leave without pay.

Claim Forms

Claim forms for filing medical and prescription drug expenses are available for printing at the Department of Community Health Web site, www.dch.georgia.gov/shbp.

The claim forms listed below are associated with filing medical and prescription claims for benefits consideration.

Claims Forms should be mailed directly to the address specified on each form.

Claim Form Name	Claim Form Use
CIGNA Choice Fund HRA	Retired Members Use this form for filing claims for CIGNA Choice Fund HRA.
CIGNA CHOICE FUND HRA	Active Members Use this form for filing claims for the CIGNA Choice Fund HRA
CIGNA claim for all options EXCEPT HRA	Active Members
CIGNA Claim for all options EXCEPT HRA	Retires
CIGNA Choice Fund Consumer Driven Health Plan Claim Form HRA &Healthy Awards	Use this form to file medical and pharmacy claims for CIGNA members
Prescription Drug Reimbursement Form	Use this form when you have paid full price for a prescription drug order at a pharmacy because the pharmacy does not accept your Medco prescription ID card, or you have not received your Medco prescription ID card
UHC Health Claim Transmittal Form	Use this form for OAP and High Deductible Plan members
UHC Pharmacy Claim Form	Use this for OAP Members

Enrolling New Employees

Introduction

The SHBP is authorized by Georgia Code 45-18-1, Georgia Code 20-2-880, and Georgia Code 20-2-910. These codes establish the basis for membership eligibility and authorize the Board of Community Health to adopt regulations for the administration of the Plan. The Board has approved, for inclusion in the Plan, Open Access Option (OAP), Health Maintenance Organization (HMO), High Deductible Health Plan (HDHP), and Health Reimbursement Account (HRA).

Full-time employees and annuitants as defined by Georgia Code who meet the eligibility requirements established by the Board shall be offered an opportunity to enroll in the State Health Benefit Plan (SHBP). The DCH is delegated the responsibility for defining the administrative policies and procedures through which eligible employees and annuitants may enroll for health benefit coverage.

New employees may participate in the SHBP provided they meet the eligibility requirements and complete the necessary forms in a timely manner. Regulations covering eligibility for coverage require uniformity in application among the options. New employees choosing not to participate upon employment cannot enroll until the next Open Enrollment Period, except under limited conditions as stated in Procedure 60-U110 and Chapter 111-4-1-.06 of the Regulations of the Board.

Defining a New Employee

A new employee is any person who was hired during the Plan Year who was not previously employed by a participating Employing Entity, within 31 days prior to the current employment date. This also includes any person whose employment and/or time status changes to meet eligibility requirements. The following are not considered new employees: Employees transferring from one Employing Entity to another or re-employed by an Employing Entity during a Plan Year with less than a 31 day break in employment, and employees returning from a period of suspension or leave without pay.

Employing Entity Responsibility

Each Employing Entity authorized by law to participate in the SHBP has the responsibility to offer enrollment in the Plan to each eligible employee. Failure to offer and explain the health coverage options to eligible employees may subject the employee or family to financial hardship and cause the employer additional administrative processing.

Each Employing Entity is responsible for providing all eligible employees with the appropriate information and enrollment materials upon employment, so that the employee may enroll in or decline coverage in the Plan. The employer should make available a copy of the Health Plan Decision Guide. The employer should also explain the benefit options and refer employees to the SHBP Call Center at 404-656-6322 or 1-800-610-1863, when necessary.

Policy-New Hires January 1, 2009 and Beyond

Effective January 1, 2009, the SHBP will limit the health benefit coverage Options offered to New Enrollees to one of the Plan's Consumer Driven Health Plan (CDHP) Options.

The available CDHP Options are:

- CIGNA Choice Fund (HRA)
- CIGNA Open Access Plus (HDHP)
- United Healthcare Definity HRA
- United Healthcare HDHP

Members will be allowed to change Options during the following Open Enrollment Period or within 31 days of meeting a Qualifying Event as defined by IRS Section 125.

Procedure

SHBP has developed two new forms to replace the single Membership Enrollment/Miscellaneous form. The two new forms are:

1. New Hire form that will list the four CDHP Options from which the New Enrollees can elect a coverage Option; and

2. Change and Miscellaneous Update form to be used for changes in coverage Option and/or Tier due to Qualifying Events; other miscellaneous changes; and addition of newly eligible dependents for existing covered SHBP members.

Each Payroll Location will be responsible for providing the appropriate form to the corresponding New Enrollee or existing SHBP member and submitting the completed form to the SHBP for processing.

Any form submitted by the Payroll Location or current Member will be reviewed for completion and to assure the correct form has been submitted for the action requested. Forms will be imaged and returned when 1) the incorrect form is used, and/or 2) the form is incomplete, altered, or is not signed and dated.

Information for returned forms will be documented in the Imaging System including the reason for return and the expected return date. The incomplete or incorrect form will not be processed into the Plan's eligibility system for enrollment.

Resubmitted forms completed and/or corrected and received on or before the expected return date will be processed, and the appropriate information will be submitted to the elected vendor (CIGNA or United HealthCare). Resubmitted forms not received timely will be processed as Denied Actions with notification submitted to the Payroll Location and employee.

SHBP Members are not allowed to change coverage Option except during the annual Open Enrollment Period or within 31 days of experiencing a Qualifying Event.
SHBP Members that Transfer between Payroll Locations must maintain the coverage Option and Tier in which originally enrolled. Space will be provided on the New Hire form for transferring employees to designate their transfer status. Therefore, the new hire limitation to CDHP options does not apply to transfers, and transferring employees will be enrolled in the original coverage Option and Tier.

There are additional policy exceptions based upon Federal and State Legislation and administrative requirements that govern the eligibility for changes in SHBP coverage Option. Most exceptions include continuous coverage as part of the requirement.

SCENARIO (Exception)	CONTINUOUS COVERAGE	OPTION AVAILABILITY
Covered dependent becomes eligible as an employee	Yes	New member may continue with Option previously enrolled in as a dependent
Covered dependent becomes eligible as an employee	No	New member must enroll in one of the CHDP Options
Break in coverage during the Plan Year	No	Must enroll with same Option and Tier *
Return from Leave of Absence Without Pay	Yes	Must enroll with the same Option and Tier
Return from Leave of Absence Without Pay during same Plan Year	No	Must enroll with the same Option and Tier
Return from Leave of Absence Without Pay spanning Plan Years	No	Must enroll in one of the CDHP Options
Enrollment in COBRA coverage	Yes	Must enroll with the same Option if eligible
Member changes residency outside of current Option's network	Yes	May enroll in any Option with network of providers that service the new residence

of providers		
Qualified Medical Child Support Order (QMCSO)	Yes	May change to Family Tier and/or change Option if child would not be covered by the network of providers of the member's current Option
Qualified Medical Child Support Order (QMCSO)	No	Must enroll in CDHP Option provided the child will be able to receive benefits
Addition of Dependents		Can change to any option
Qualifying Event allowing change in Option	Yes	May change to in any Option
Enrollment of Surviving Spouse	Yes	Must enroll in same Option as deceased spouse

* If a member meets a Qualifying Event during a break in coverage in the same the Plan Year, the member may file for a change in coverage within 31 days of re-employment.

Employee Eligibility Requirement

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

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

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

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

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

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

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

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

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

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

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

3. A person employed in a professionally Certificated Capacity or Position in the public vocational and technical schools operated by a local school system;
4. A person employed in a professionally Certificated Capacity or Position in the Regional Educational Service Areas of Georgia;

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

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

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

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

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

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

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

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

Dependent Eligibility Requirement

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1. The Surviving Spouse must make written application no later than thirty-one (31) calendar days following Coverage termination as a result of the death of the Retired Employee; and

2. The parties must have been married at least one full year prior to the death of the Retired Employee; and

3. The Surviving Spouse agrees to pay the monthly premium payment established by the Board in accordance with the established requirements; and

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

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

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

Who Is Eligible for Coverage

WHO IS NOT ELIGIBLE FOR COVERAGE

Who	Description	Who Determines Eligibility
Ineligible Dependent	▪ SHBP dependent coverage **DOES NOT** include: ▪ Former spouse ▪ Fiancé ▪ Parents ▪ Married or formerly married children ▪ Children age 19 or older who do not qualify as full-time students or disabled dependents ▪ Children 26 or older who are not already covered as a disabled dependent ▪ Children in military service ▪ Grandchildren who cannot be considered eligible dependents ▪ Stepchildren who do not live in employees home at least 180 days per year ▪ Anyone living in employee's home that is not related by marriage or birth, unless otherwise noted.	**SHBP Determines Eligibility**

Eligibility Time Limits

The Employing Entities must offer new employees who meet the eligibility requirements the opportunity to enroll in the SHBP before or on the first day of employment. Completed Forms must be signed by the employee within 31 days of employment.

NOTE: **EMPLOYEES WHO DO NOT COMPLETE THE NECESSARY ENROLLMENT FORMS WITHIN THE 31 TIME FRAME ALLOWED WILL NOT BE ELIGIBLE TO PARTICIPATE UNTIL THE NEXT OPEN ENROLLMENT PERIOD UNLESS THEY EXPERIENCE A QUALIFYING EVENT.**

When Coverage Begins

New employees selecting coverage under the SHBP will be covered on the first day of the month following one (1) full calendar month of employment provided the employee is at work, on paid leave, or performing their normal duties at a place other than the customary place of employment on the effective date of coverage. A full calendar month of employment means that the new employee's hire date was on or before the first calendar day of the month preceding the effective date of coverage and the new employee was in full pay status not less than 75 percent of the month. The first calendar day of the month excludes Saturday, Sunday or official State holiday, unless the employee is normally required to perform their routine duties on these days. Documentation of full pay status may be required to establish eligibility for coverage.

Salary deductions/reductions for health coverage must be withheld from the employee's paycheck the month that immediately precedes the effective date of coverage.

WHEN COVERAGE BEGINS

For Employee	If Employee Enrolls	Coverage Begins
	During an Open Enrollment period	On January 1 of the new Plan Year
	As a new employee	On the first day of the month following one full calendar month of employment
	When employee is reinstated or returns to work from unpaid leave of absence that occurred during the Open Enrollment period	On the first day of the month following the return or, if a judicial reinstatement, on the day specified in the settlement agreement
	When you have a qualifying event	On the first day of the month following the request
Transferring Employee	**Transfer Between Participating Employers**	
	▪ Contact the previous employer to coordinate continuous coverage ▪ Employees must continue the same coverage, unless they had a Qualifying Event that made them ineligible to continue the coverage	There is no coverage lapse when the employment break is less than one calendar month and the new employer deducts the premium from employees first pay check

WHEN COVERAGE BEGINS

For Employee's Dependent	Add this Dependent	Coverage Takes Effect
Within 31 days prior to or after the Qualifying Event	**A baby** Copy of certified birth certificate, or A certification letter of birth required Receipt of documentation can occur anytime during the plan year	On the first day of the month following the request; or on the day the child is born, if the family premium is paid for the birth month
	An Adopted Child Copy of certified adoption certificate required. Receipt of documentation can occur anytime during the plan year	When Employee already has family coverage: ▪ On the date of legal placement and physical custody When Employee changes to family coverage within 31 days of the event ▪ On the date of legal placement and physical custody, if the family premium is paid for the time of placement and custody
	A New Spouse Copy of marriage certificate required. Receipt of documentation can occur anytime during the plan year	When Employee already has family coverage: ▪ On the day of marriage When Employee has single coverage: ▪ On the first day of the month following the request or date of marriage whichever is later
	Stepchild(ren) Copy of certified birth certificate showing the spouse as the natural parent; and a copy of the certified marriage license showing the natural parent is the spouse; and notarized statement that the dependent lives in the home at least 180 day per calendar year	When Employee has single coverage: ▪ On the first day of the month following the request When Employee already has family coverage: ▪ On the first day of the month following the request
Note: When a dependent is added, SHBP requests dependent verification documentation, the documentation must be submitted in order to cover the dependent. Receipt of documentation can occur anytime during the plan year.		

Pre-existing Conditions Benefit Limitation Period

The Federal Health Insurance Portability and Accounting Act of 1996 (HIPAA) legislation contains provisions which allow health plan members to reduce the SHBP 12 month pre-existing conditions benefit limitation period under the OAP. The pre-existing conditions policy limits benefits payable for treatment of a pre-existing condition to $1,000.00 until the patient is free of treatment for six months or has been insured for a year under the SHBP. The pre-existing policy applies to employees and dependents (except a newborn child) at the time they are enrolled. A Pre-Existing Condition is any sickness, injury or other condition for which medical advice, diagnosis, care or treatment, including prescription medication, was recommended or received within six months immediately preceding a Member's coverage effective date under the Plan.

The 12 month pre-existing conditions benefit limitations period will be reduced by the length of time that creditable coverage existed under an employer sponsored group health plan. An employer sponsored group health plan is required to issue a Certificate of Creditable Coverage for ea7ch covered person whenever coverage terminates and upon request for two years following coverage termination under that plan. The following conditions apply:

- The member must provide a Certificate of Creditable Coverage. If you are enrolling a new hire, a 63-day period is measured from the last day of prior coverage up to their hire date

- The creditable coverage must not have time periods of non-coverage that lasted for more that 63 days prior to the date of employment or the waiting period for SHBP coverage when coverage begins at a time other than employment. When the most recent creditable coverage terminated less than 63 days prior to the waiting period for SHBP coverage, the pre-existing limitation period will be reduced by the number of months of prior creditable coverage excluding the SHBP waiting period

- The PEC limitation period does not apply to coverage for pregnancy, newborn, newly adopted children or a child placed for adoption under the age of 18, if the child becomes covered within 31 days of birth or adoption

- Enrollees are treated as new members, subject to the PEC limitation period, if they are enrolled in the OAP after a coverage break of four or more months

- The SHBP pre-existing conditions policy limits will apply to each covered person for whom creditable coverage has not been documented. See the Regulations of the Board of Community Health, Chapter 111-4-1-.10

DCH Surcharge Policies

A spousal surcharge will be added to the member's monthly premium if the member elects to cover the spouse and the spouse is eligible for coverage through his/her employment but chose not to take it. If the member's spouse is eligible for coverage through SHBP through his/her employment, the spousal surcharge will be waived. The spousal surcharge can be removed in certain circumstances by completing the spousal surcharge affidavit and attaching the required documents. Details can be found on the DCH Web site, www.dch.georgia.gov/shbp_plans .

A tobacco surcharge will be added to member's monthly premium if the employee or any of the employee's covered dependents have used tobacco products in the previous 12 months. The tobacco surcharge may be removed by completing the tobacco cessation requirements. Details can be found on the DCH Web site, www.dch.georgia.gov/shbp_plans.

STATE HEALTH BENEFIT PLAN (SHBP)
SPOUSAL SURCHARGE POLICY
Effective January 1, 2010

Currently the SHBP charges members a $40 per monthly spousal surcharge if the spouse is eligible for coverage through his/her employer and the spouse elects not take the coverage.

A member may have the spousal surcharge removed if the required documentation, as indicated on the Spousal Surcharge Affidavit Form is submitted. The request may be made anytime during the plan year. Removal is on a prospective basis only and SHBP will not make refunds for previous health deduction premiums as Internal Revenue Service rules do not allow premium changes to be made retroactively.

All requests must be submitted on a "Removal of Spousal Surcharge Affidavit" and members must submit the appropriate documentation as listed below:

- **Spouse is enrolled in his/her employer's health coverage:** A copy of the insurance card, letter from the insurer, or letter from the employer is required

- **Spouse is employed but is not eligible for or not offered health benefits through the employer**: A letter, on the employer's letterhead with an employer contact person's name and phone number that states spouse's name and that spouse is not offered health benefits is required

- **Spouse is employed and also covered through his/her employer under the SHBP**. A copy of the spouse's insurance card is required or his/her Social Security number is given so SHBP can verify coverage

- **Spouse is unemployed and not covered under any other health coverage**: A copy of the prior year's federal tax return (with financial information blocked out) showing

unemployed status is required. If recently unemployed, a signed, notarized statement giving the name of spouse and attesting that spouse is currently unemployed and not covered under any other health coverage

Steps to Remove Surcharge

1. Member must complete the "Removal of Spousal Surcharge Form" available on the Georgia Department of Community Health (DCH) Web site www.dch.georgia.gov/shbp and attach the corresponding documentation

2. Member submits the signed affidavit and appropriate documentation to his/her benefits/ payroll office

3. Payroll location fills out the deduction information (must show a minimum of one month's surcharge deduction) and forwards the "Removal of Spousal Surcharge Form" and documentation to:

SHBP
P.O. Box 1990
Atlanta, GA 30303-1990

4. Payroll location changes the deduction on its system

5. SHBP receives the form and documentation; reviews to determine appropriate documentation is attached and if correct, removes the surcharge

6. Once SHBP has removed the surcharge, it will be reflected in your next month's billing statement

STATE HEALTH BENEFIT PLAN
REMOVAL OF SPOUSAL SURCHARGE AFFIDAVIT
Effective January 1, 2010

Policyholder/Plan Member Name _____ SS #: _____

Check appropriate box, sign, and date this form. You must submit it to your payroll location/benefit coordinator to have the required deduction information completed at the bottom of this form. You will be charged the surcharge for a minimum of one month. Retro-deductions will NOT be refunded.

- My spouse is enrolled in his/her employer's health coverage. A copy of the insurance card, letter from the insurer, or letter from the employer is attached
- My spouse is employed but is not eligible for or not offered health benefits through the employer. A letter, on the employer's letterhead with an employer contact person's name and phone number, that states your spouse's name and that your spouse is not offered health benefits is attached
- My spouse is employed and also covered through his/her employer under the State Health Benefit Plan. A copy of my spouse's insurance card is attached
- My spouse is unemployed and not covered under any other employer-sponsored health coverage. A copy of the prior year's federal tax return (with financial information blocked out) showing unemployed status is attached. If recently unemployed, a signed, notarized statement is attached stating the name of my spouse and a statement attesting that my spouse is currently unemployed and not covered under any other employer-sponsored health coverage

I do hereby attest that the above information is true and correct to the best of my knowledge. I further acknowledge and understand that I may be subject to a fine of not more than $1,000 or imprisonment for not less than one and no more than five years, or both, and I may lose health coverage for one year, if I knowingly and willfully make a false or fraudulent statement or representation to the Georgia Department of Community Health regarding the information reported on this form or other information pursuant to O.C.G.A. Section 16-10-20.

Signature_____ Date _____

Note: Once you have read and signed this affidavit you must submit it to your payroll location/benefit coordinator to have the below required deduction information completed. If this form is received without a signature and the appropriate box checked, it will be returned to your payroll location and will delay processing.

Department/School System Use Only		
Payroll Location #	*Date of first deduction	Deduction Amount

SP01 (rev. 3.16.09)

STATE HEALTH BENEFIT PLAN (SHBP)
TOBACCO USERS CESSATION POLICY

Tobacco users who elect to quit smoking can have the tobacco surcharge removed if they attend an SHBP approved tobacco cessation class offered by the American Cancer Society, American Lung Association, or listed on the Approved Tobacco Cessation Programs List.

The tobacco user must be smoke free for 60 days, complete an SHBP approved tobacco cessation class, obtain a certificate of attendance and complete an SHBP Affidavit Form certifying compliance with these requirements.
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American Cancer Society Fresh start Tobacco Cessation Program
Numerous tobacco cessation classes will be offered through the American Cancer Society (Fresh Start) in various locations throughout the state. Members who are interested in attending these classes should contact the American Cancer Society at **1-888-227-6333.** The American Cancer Society does not charge a tobacco cessation enrollment fee for these classes.

The American Cancer Society is willing to train volunteers as FreshStart facilitators. Members interested in becoming class facilitators for his/her departments should contact Brenda Wright at 404-816-7800 ext. 6451 or Gwen Bryant at 478-719-3055.

American Lung Association
Numerous tobacco cessation classes will be offered through the American Lung Association in various locations throughout the state. Members who are interested in attending these classes should contact the American Lung Association at **229-435-3626 or 888- 436-3626.**

All smoking cessation programs must follow the CDC and U.S. Preventive Task Force guidelines. The Georgia Tobacco Quit Line (1-877-270-STOP) is available as a resource to smoking employees. However, the Quit Line does not offer cessation classes, and therefore, does not qualify for removal of tobacco surcharges. Members must attend classes approved by the SHBP.

Attached is an updated listing of approved programs that are offered at hospitals. For other classes, you should contact the American Cancer Society, American Lung Association. SHBP members should check the Department of Community Health Web site for any updates at www.dch.georgia.gov/shbp.

STATE HEALTH BENEFIT PLAN
APPROVED TOBACCO CESSATION PROGRAMS

The SHBP does not cover any fees. Members are responsible for payment of fees. Contact each individual facility for enrollment fees. Remember you must be tobacco free for 60 days before the surcharge can be removed.

American Cancer Society -1-888-227-6333 - Various locations throughout the State
American Lung Association - 1-888-436-3626 - Various locations throughout the State

Classes listed below are in addition to those offered above.

County	City	Facility	Contact Name	Phone
Baldwin	Milledgeville	Oconee Regional	Kay Marshall	478-454-3945
Ben Hill	Fitzgerald	Dorminy Medical Center	Bridgett Busbin	229-424-7186
Bibb	Macon	Medical Ctr of Central GA	Kevin Carter	478-633-5090
Bullock	Statesboro	East GA Regional Outreach Center Outreach Center Outreach Center	Donna Wick Allison Judge Christopher Judge Sharon Sable	912-486-1132 912-739-3019 912-739-3019 912-764-4310
Camden	Kingsland	Fresh Start-Coastal Medical Access Project	Barbara Walters	912-729-9680
Chatham	Savannah	Memorial Health University Medical Center	Cindy Davis	912-350-8549
Cherokee	Canton	CDSD Central Office Canton Complex	Cherokee County Benefit Office	770-704-4264
Cobb	Austell	WellStar Cobb	Marilyn Reasor	770-644-1565
Cobb	Marietta	WellStar Kennestone	Marilyn Reasor	770-644-1565
Cobb	Marietta	Lung Health of Marietta	Gail Ullrich	770-928-4833
Coffee	Douglas	Coffee Reg. Medical Ctr.	Brenda Reynolds	912-384-1900
Coweta	Newnan	Newnan Hospital	Jane Rohan	770-254-3668

County	City	Facility	Contact Name	Phone
Dekalb	Atlanta	Emory University	Eddie Gamble	404-727-4328

Dodge	Eastman	Dodge County Hospital	Becky Smith Michelle Bryan	478-448-4122
Dougherty	Albany	Phoebe Putney Memorial Hospital	Daphanie Davis	229-312-7040
Dougherty	Albany	Dougherty Co. Health Dept.	Alice Rodman	229-430-6230
Effingham	Springfield and Rincon	Effingham Hospital	Claudette Jordan	912-754-0171
Evans	Claxton	Claxton Poultry	Allison Judge Christopher Judge	912-739-3019
Fayette	Fayetteville	Piedmont Fayetteville Hospital		1-866-900-4321
Floyd	Rome	Floyd County Health Dept.	Ann Carter	706-802-5409
Forsyth	Cumming	Northside Hospital-Forsyth	Donna Olaiya	770-844-3497
Fulton	Atlanta	Crawford Long	Eddie Gamble	404-727-4328
Fulton	Atlanta	Emory University	Eddie Gamble	404-727-4328
Fulton	Atlanta	Northside Hospital	Missy Smith	770-667-4132
Fulton	Atlanta	Piedmont Hospital	Nita Cardic	1-866-900-4321
Fulton	Atlanta	Dept. of Human Resources, Worksite Wellness Program, 2 Peachtree St.	Martha Dismer	404-651-7324 healthmatters@dhr.state.ga.us
Glynn	Brunswick	SE Georgia Health System	Brenda Antonio Brandy McDonald	912-466-3375 912-739-3019
Gwinnett	Lawrenceville	Gwinnett Medical Center	Cheryl Odell	678-312-3690 678-312-3692
Hall	Gainesville	Northeast Georgia Medical Center	Wanda Edwards David Paris Ginger Maddox	770-533-8294 770-533-8296 770-533-8264
Henry	Stockbridge	Henry Medical Center		770-389-2143
Houston	Warner Robbins and Perry	Houston Medical Center	Sandra Eaton	478-923-9771
Laurens	Dublin	Heart of GA Healthy Start	Laura Vertin	800-880-0117
Liberty	Hinesville	Liberty Regional Medical Center	Debra Wells	912-369-9416
Macon	Montezuma	Flint River Hospital	Monica Hood Bonnie Smith	478-472-3234 478-472-3233

County	City	Facility	Contact Name	Phone
Muscogee	Columbus	Columbus Health Dept.	Mark Ellis Homer Wells	706-321-6239 706-321-6239
Muscogee	Columbus	John B. Amos Cancer Center	Rubye Stafford, RN	706-571-1102
Muscogee	Columbus	Muscogee Co. School Dist.	Darlene Shirley	706-748-2233
Pulaksi	Hawkinsville	Taylor Regional Hospital	Melissa Johnson	478-783-0232
Pickens	Jasper	Piedmont Mountainside Hospital	Cindy London	706-301-5507
Richmond/ Columbia	Augusta	University Hospital		706-774-8900
Richmond/ Columbia	Fort Gordon	Health and Wellness *Must be Military Care Elig.		706-787-6756
Richmond	Augusta	Doctors Hospital		706-651-3232
Rockdale	Conyers	Rockdale Medical	Tim Andrews	770-918-3851
Spalding	Griffin	Spalding Regional Hospital		770-467-6153
Tift	Tifton	Tift Regional Medical Center	Jackie Laska	229-353-6281
Upson	Thomaston	Upson Regional	King Davis	706-647-8111
Wayne	Jesup	Wellness Center	Pam Holmes	912-739-3019

STATE HEALTH BENEFIT PLAN (SHBP)
TOBACCO CESSATION AFFIDAVIT FORM

Policyholder/Plan Member Name_____

Social Security Number_____

Health Plan Option: (check one) **CIGNA OAP, CIGNA HDHP, CIGNA HRA, UHC OAP, UHC HDHP, UHC Definity HRA**

□ I hereby certify that all covered members have not used any tobacco products within the last 60 days. In addition, I have attached a certificate of attendance affirming that each dependent that previously used tobacco has completed all classes in a SHBP approved tobacco cessation program

□ I understand that as a SHBP member I have the responsibility to read the current Decision Guide and the Summary Plan Description (SPD) of my chosen health benefit option

□ I understand it is my responsibility to access the open enrollment Web site each year to make elections and answer the surcharge questions to prevent default surcharges. I also understand that this document must be completed, all boxes checked and returned to my payroll benefit coordinator in order to remove the tobacco surcharge currently being applied to my health coverage premium. In addition, if I or any covered dependents resume using any tobacco products after attending these classes I will complete the necessary document to notify the Plan. No refund in premium(s) will be made for any previous deductions that included the surcharge amounts. Internal Revenue Service rules require all premium charges to be prospective.

I do hereby attest that the above information is true and correct to the best of my knowledge. I further acknowledge and understand that I may be subject to a fine of not more than $1,000 or imprisonment for not less than one and no more than five years, or both, and I may lose health coverage for one year, if I knowingly and willfully make a false or fraudulent statement or representation to the Georgia Department of Community Health (DCH) regarding the information reported on this form or other information pursuant to O.C.G.A. Section 16-10-20.

Signature_____ **Date** _____

Note: Once you have read and signed this affidavit you must submit it to your payroll location benefit coordinator to have the required deduction information completed. If this form is received without a signature, all boxes checked and the tobacco cessation attendance certificate, it will be returned to your payroll location and will delay processing.

Department/School System Use Only		
Payroll Location #	**Date of first deduction**	**Deduction Amount**

STATE HEALTH BENEFIT PLAN
NON-TOBACCO USERS SURCHARGE WAIVER POLICY
JANUARY 1, 2010

Non-tobacco users have the opportunity to have their tobacco surcharge removed by completion of a wellness requirement. Members will need to answer a health assessment questionnaire and access wellness information on their Health Plan's Web site. Removal is on a prospective basis only and SHBP will not make refunds for previous health deduction premiums as Internal Revenue Service rules do not allow premium changes to be made retroactively.

Specific instructions for accessing the Health Assessment Questionnaire and wellness information are attached. Members will need to access the website offered by the Health Plan Option in which they are enrolled.

Members who have not used tobacco products in the past 12 months and complete this program will have the tobacco surcharge removed from future premium payments for the Plan Year.

Upon completion of the wellness requirement, members should obtain the Non-Tobacco User's Affidavit Form available online at www.dch.georgia.gov/shbp_plans . Once the member has read and signed the affidavit, he must submit it to his payroll location/benefit coordinator for submission to the SHBP.

STATE HEALTH BENEFIT PLAN (SHBP)
NON-TOBACCO USERS AFFIDAVIT FORM
January 1, 2010

Policyholder/Plan Member Name_____

Social Security Number_____

Health Plan Options: (Circle One) **UHC OAP, UHC HDHP, UHC HRA, UHC HMO, CIGNA OAP, CIGNA HMO, CIGNA HRA, CIGNA HDHP**

□ I hereby certify that all covered members have not used any tobacco products within the past twelve months
□ I have completed a Health Risk Assessment Program with the above Health Plan
□ I have downloaded and read wellness information in an area that is of interest to me
□ I understand that as a SHBP member I have the responsibility to read the current Decision Guide and the Summary Plan Description of my chosen health benefit option
□ I understand it is my responsibility to access the Open Enrollment Website each year to make elections and answer the surcharge questions to prevent default surcharges

I also understand that this document must be completed, **all boxes checked** and returned to my payroll benefit coordinator in order for the removal of the tobacco surcharge. The effective date of the change will be dependent upon the payroll schedule for my employer. No refund in premium(s) will be made for the previous deductions that included the surcharge amounts. Internal Revenue Service rules require all premium charges to be prospective.

I do hereby attest that the above information is true and correct to the best of my knowledge. I further acknowledge and understand that I may be subject to a fine of not more than $1,000 or imprisonment for not less than one and no more than five years, or both, and I may lose health coverage for one year, if I knowingly and willfully make a false or fraudulent statement or representation to the Georgia Department of Community Health regarding the information reported on this form or other information pursuant to O.C.G.A. Section 16-10-20.

Signature_____ **Date** _____

Note: Once you have read and signed this affidavit you must submit it to your payroll location benefit coordinator to have the below required deduction information completed. If this form is received without a signature and all boxes checked, it will be returned to your payroll location and will delay processing.

Department/School System Use Only		
Payroll Location #	**Date of first deduction**	**Deduction Amount**

TC03 (rev. 3/16/09)

Instructions for Accessing the Health Assessment

CIGNA

1. Navigate to **www.myCIGNA.com** and log in using your User ID and Password, and then select "Go." If you are not yet registered for myCIGNA.com, you will need to do that first:
a. On the www.myCIGNA.com log-in screen, in the bottom-left menu, select "Register"
b. Follow the registration instructions and enter the required information. When finished, you will be asked to log in using your new User ID and Password
2. Once logged in, select the "MY PLANS" tab near the top of the page. On the right side of the next page you'll see a box labeled "I want to...." Select the link that says "Take *my health assessment*"
3. On the next page, select your name. A new window will open to the ***my health & wellness center*** log-in page
4. On the log-in page, under "New Users," select "Register for ***my health & wellness center***."
5. Follow the registration instructions and complete all required fields
6. When registration is complete, the next page will be the ***my health & wellness center*** home page. From here, you can take your health assessment or join an Online Health Coaching Program

Know Your Numbers
my health assessment will request your blood pressure, total cholesterol, HDL cholesterol, height, weight, and waist circumference. If you are unsure what your blood pressure and cholesterol values are, you may answer "I'm Not Sure"
Please note**:** Your health assessment registration process provided above is only required for the first time you access your health assessment. In the future, after accessing your health assessment for the first time, you will need only to navigate through step 3 above and you will automatically be logged in to ***my health & wellness center***
Your covered spouse or adult child (age 18 and older) needs independent access to my health & wellness center in order to complete his/her own health assessment. You must first set this up on his/her behalf. Please see *"How to Login for Dependents"* Instructions

United HealthCare – OAP, Choice (HMO), High Deductible Health Plan and Definity HRA
1. Click on www.myuhc.com
2. Click on "Site Login" and enter Username and Password or "Need a user name and password" if a first time user
3. Click on "Health & Wellness" tab located on the top right hand corner
4. On the Health & Wellness homepage, click on "Take a Health Assessment" located in the middle of the page
5. Read the privacy information and then click on "Launch University of Michigan Health Assessment" in the middle of the page
6. Answer the questions and hit "Submit to the University of Michigan for Analysis" at the bottom of the questionnaire
7. Review your personal results profile. You may also print for your records. Your completed health assessment will personalize your online health & wellness experience

8. In addition to completion of the Health Assessment, you must download and review information from any wellness topic of interest

Name	Telephone #
CIGNA	800-633-8519
United Healthcare	
OAP	877-246-4189
High Deductible Health Plan	877-246-4189
Definity HRA	800-396-6515
Choice (HMO)	877-246-4189

These policies and forms are also available for printing at the DCH web site at www.dch.georgia.gov/shbp.

Eligibility Appeals

SHBP will handle all Eligibility Administrative Reviews. Eligibility Appeal forms are available through the employing entity or the DCH website, www.dch.georgia.gov/shbp. There are three levels of Eligibility Appeal within SHBP that must be followed in succession. The following Job Aid describes each level of eligibility appeal and required forms:

SHBP Job Aid: SHBP Eligibility Administrative Review, Appeals

Appeal Level	Form Name	Appeal Steps/Form Use
First	Telephone Review	The telephone review is the first level of appeal and should be completed within 90 days of the explanation of benefits denying benefits due to eligibility.
Second	Eligibility Administrative Review Form	This form should be used after contacting Member Services and requesting a telephone review within 90 days of the eligibility denial. The administrative review form is used as the second level of appeal under the plan and must be filed within 90 days of the denied action concerning your eligibility.
Third	Formal Appeal Review Form	This form should be used after the telephone review and administrative reviews are completed. The formal appeal must be filed within 60 days of the administrative review response. The formal appeal is the final step of the appeal process.

FORMAL APPEAL INSTRUCTIONS

The Formal Appeal is the final step in the three step process. If you request for Administrative Review is denied, you may file a Formal Appeal, which must be postmarked within 60 days following the date of Administrative Review decision. To file a Formal Appeal, you must complete all applicable sections on this form and attach a copy of the decision of the Administrative Review. If the formal appeal is submitted before the Administrative Review is completed, the formal appeal will be returned to you.

Generally, a decision by the Formal Appeal committee will be issued within ninety (90)days following receipt; however, the number of days may be extended by notice from the Department of Community Health. The written notice of the decision by the Committee is the final step in the administrative proceedings and will exhaust all administrative remedies.

Please forward all written requests for Eligibility Administrative Review - Appeals along with completed appeal forms to:

State Health Benefit Plan
Membership Correspondence Unit
P.O. Box 1990
Atlanta, GA 30303-1990

All member correspondence sent to the Plan should include the enrolled member's Social Security Number (SSN) to prevent a delay in processing the request.

Declination of Coverage

The Employer has specific responsibilities under the Plan and includes enrolling all eligible full-time employees in the Plan, unless the employee declines coverage or is ineligible for coverage due to employment status. (e.g., part-time employee). The employee must provide either a Membership Form or a Declination Form during the first 31 days on the job.

The Declination of Health Benefit Coverage Form must be completed by a member/employee who declines coverage under the State Health Benefit Plan. The employee should review the statement and certification in Section III and sign the appropriate statement.

Coordination of Benefits

Non-Duplication of Benefits

The SHBP coordination of benefits policy has changed to a non-duplication of benefits. If you are covered by two group health plans, the benefit under SHBP will be no greater than it would have been if there was no coverage other than that of SHBP.

Dual Coverage Eligibility

A new employee whose spouse is currently enrolled for coverage under the SHBP may enroll for any type of coverage (single or family). The new employee should consider carefully whether or not the dual coverage would provide sufficient additional medical benefits to offset the additional health insurance premium.

SHBP Job Aid :

Enrolling New Employees (Procedure 60-U100)

New employees eligible to participate in the SHBP must complete the required forms in order for the enrollment to be complete. **SHBP must receive all required forms within the 31** day enrollment period**.** The required forms are:

1. A Membership Form (SHBP 66-091), if the employee is enrolling for health benefits coverage
2. A Declination of Health Benefit coverage (SHBP 66-004), if the employee is declining or is not eligible for coverage

Procedure**:**

1. Determine the eligibility of each new employee under the work status requirements.
   a) If the individual is not eligible for health benefit coverage under the SHBP, he/she should complete the Declination of Health Benefit Coverage. Process the form in accordance with Procedure 60-U200
   b) If the individual is eligible for health benefit coverage under the SHBP, determine the

options for which he/she is eligible. Supply the individual with appropriate information

- New employees hired prior to 1/1/09 are eligible for the OAP, HMO, HRA, and HDHP options. Provide the appropriate State Health Benefit Plan Decision Guide
- New employees hired after 1/1/09 are eligible for the HRA and HDHP plans only. Provide the 2010 New Hire Decision Guide

2. Allow an eligible new employee to choose the option and tier desired. If the individual declines coverage under the SHBP, have him/her complete a Declination of Health Benefit Coverage. The form should be processed in accordance with Procedure 60-U200.

   Advise the individual that if coverage is declined upon employment, enrollment at a later date is allowed only during an Open Enrollment period, except at the time of a qualifying event as outlined in Procedure 60-U110 and Chapter 111-4-1-.06 in the Regulations of the Board. For persons who desire to enroll for coverage under the SHBP, proceed to Step 3.

SHBP Job Aid

Enrolling New Employees
(Procedure 60-U100)

3. Have a new employee who desires to enroll in health benefit coverage complete the following sections of the Employee Enrollment/Transfer Form (SHBP 66-091).

   a) Section I: Employment Identification - The employee should write their Social Security number, name, address, telephone number, date of birth and sex as clearly as possible

   b) Section II: Department/School -System Use Only - To be completed by Employer, giving first deduction date and location number

   c) Section III: Coverage – The employee should mark the coverage option selected or indicate if he/she is transferring from another covered entity

   d) Section IV: Tobacco and Spousal Surcharge Questions –Questions must be answered to enroll in coverage

   e) Section V: Coverage Tier-The employee should mark the appropriate coverage tier

   f) Section VI: Dependents: The employee should list the dependents to be covered under

the Plan. The appropriate information for each dependent should be given. Any required documents (refer to the back of the Membership Form for determining dependent eligibility requirements) should be attached to the form and agree to abide by the terms, conditions and instructions

g) Section VII: Attestation: The employee should read the Attestation, sign, and date each copy of the form By signing the Attestation, the employee acknowledges having read the Terms, Conditions, and Instructions on the back of the form

4. Review the Membership Form for accuracy and completeness. Complete Section II, Department/School System Use Only." If the form is not properly completed, it will be returned to the Employing Entity for the necessary information. Please verify that ALL information is complete.

5. Inform the employee about the pre-existing conditions benefit limitation under the OAP and how creditable coverage can reduce the limitation period. If necessary, assist the employee in obtaining a Certificate of Creditable Coverage from a prior employer.

6. Inform the employee when payroll deductions will begin and when coverage will become effective.

   a) The salary deduction/reductions for premiums should begin the month that immediately precedes the effective date of coverage. Internal Revenue Service Tax-qualified Cafeteria Plan Rules require premiums be collected through payroll deductions/reductions

   b) Coverage will begin the first of the month following the completion of one full calendar month of employment provided that the employee is at work, on paid leave, or performing their normal duties at a place other than the customary place of employment

Procedure 60-U110:
Qualifying Life Events - Enrollment & Changes in Coverage
Effective 07-01-2007

QUALIIFYING EVENTS - ENROLLMENTS & CHANGES IN COVERAGE

Introduction

The Regulations of the Board of Community Health under which the SHBP operates comply with applicable state and federal legislation including the Internal Revenue Services rules that govern cafeteria plans, Health Insurance Portability and Accountability Act, and Department of Labor. *These regulations require the health benefit coverage selection made by employees at the time of employment or during an Open Enrollment period to be binding for the duration of the Plan Year. Employees are not allowed to increase or decrease coverage, or to add or*

delete coverage except under limited Qualifying Life Event (Qualifying Event) conditions as outlined in Chapter 111-4-1-.06 in the Regulations of the Board. If a change in family status, employment status or change in insurance coverage occurs, any change made by the employee must be because of and consistent with such change. The intent of allowing change is to protect the employee and their family from loss of health coverage.

Employing Entity Responsibility

When the employing entity is notified by the employee that a Qualifying Event has occurred, the employing entity should determine if the event, as defined in this procedure and in the Regulations, qualifies the employee to discontinue, enroll or change coverage tier or option. If the criteria for a Qualifying Event is met and filed within the specified time frame, the employing entity should process the employee's request in the month it is received.

Time Limitations and Proper Notification

A Qualifying Event is defined as a change in family status, employment status, or change in insurance coverage. When a qualifying event has occurred, the employee must report the change to their employing entity within the specified time frame. Enrollment in or changes to the current health benefit selection that are not received by SHBP within thirty-one (31) days of the Qualifying Event will not be allowed. Please refer to the Job Aid on Qualifying Life Events - Enrollment & Changes in Coverage/ Procedure 60-U110 listed in this section of the Administrative Guide.

Effective Date of Changes

Requests to change or discontinue coverage must be received by SHBP no later than 31 days following the Qualifying Event unless otherwise noted in the specific provision of the Regulations. The effective date of the change or discontinuation shall be on the first of the month following receipt of the request or date of the Qualifying Event, unless otherwise noted.

Changes in health benefit coverage may not be made retroactively except to cover a **newborn dependent** from birth or for the correction of administrative error. Requests resulting in an enrollment or change from single to family coverage must be requested up to 31 days before the event or within 31 days following the event. For the anticipated birth of a dependent, the Plan will allow an enrollment or change to family coverage to be effective the first of the month in which birth is anticipated; only if a member requests the family coverage to become effective at birth can the employing entity take a payroll deduction/reduction for a retroactive coverage effective date.

The birth of a newborn dependent is the **only** Qualifying Event that allows a retroactive coverage effective date and the appropriate deduction/reduction must be taken from the employee's earnings in the month the request is received The employing entity must advise the employee multiple deductions will be taken in the next payroll cycle.

When changing to family coverage due to the Qualifying Event of a newborn dependent's birth, the employee has the option to add other qualifying family members to the coverage; required dependent documentation will be requested. If the employee chooses not to cover the newborn from birth, the employing entity should document this fact in the employee's benefit file.

SHBP Job Aid

SHBP Qualifying Events
(Procedure 60-U110)

Event	Time Limitations	Required Documentation	Additional Information
Newly Hired Employee	31 days following the Hire Date	Membership Form	The employee may: ▪ enroll in coverage ▪ enroll eligible dependents ▪ decline coverage (SHBP Declination of Coverage required within 31 days of the Qualifying Event
Marriage	31 days following the Qualifying Event	Certified copy of Marriage Certificate	The employee may: ▪ enroll in coverage ▪ enroll eligible dependents ▪ discontinue coverage (letter from other plan documenting coverage is required to discontinue coverage) within 31 days of the Qualifying Event
Birth	31 days following the Qualifying Event	Copy of the certificate of birth or letter of certification of birth	The employee may: ▪ enroll in coverage ▪ enroll eligible dependents ▪ change to any available option within 31 days of the Qualifying Event
Adoption	31 days following the Qualifying	Adoption certificate or	The employee may: ▪ enroll in coverage

	Event	letter of certification of birth	▪ enroll eligible dependents ▪ change to any available option ▪ within 31 days of the Qualifying Event
Event	**Time Limitations**	**Required Documentation**	**Additional Information**
Divorce	31 days following the Qualifying Event	Copy of Divorce Decree and loss of coverage documentation	The employee may: ▪ enroll in coverage ▪ enroll eligible dependents ▪ change to Single Coverage ▪ change to family coverage within 31 days of the Qualifying Event
Former spouse loses coverage or plan cancelled (resulting in loss of dependent children's coverage)	31 days following the Qualifying Event	Letter from the other plan documenting coverage loss	The employee may: ▪ enroll in coverage ▪ enroll eligible dependents within 31 days of the Qualifying Event
Spouse or only enrolled dependent's employment status changes, resulting in a gain of coverage under a qualified plan .	31 days following the Qualifying Event	Letter from the employer documenting effective date of coverage eligibility and who is covered under the new plan	The employee may: ▪ change to Single Coverage ▪ drop coverage
Loss/discontinuation of coverage through other employment,	31 days following the Qualifying Event	Letter from the other employer, Medicaid, or Medicare	The employee may: ▪ enroll in coverage ▪ enroll eligible dependents

Medicaid, or Medicare (employee or dependent)		documenting date of loss and reasons for the loss/discontinuation of coverage	▪ change to any available option within 31 days of the Qualifying Event
New coverage under Spouse's employer's plan	31 days following the Qualifying Event	Letter from other plan documenting coverage to include reason for enrollment, effective date of coverage and list of all persons enrolled.	The employee may: ▪ change to Single Coverage ▪ discontinue coverage within 31 days of the Qualifying Event

Event	Time Limitations	Required Documentation	Additional Information
Employee or spouse is activated into military service	31 days following the Qualifying Event	Copy of Military Orders	The employee may: ▪ enroll in coverage ▪ change to single coverage within 31 days of the Qualifying Event ▪ discontinue coverage
Employee's spouse makes an Open Enrollment change under the spouse's employer's plan, creating an overlap or break in coverage because spouse's coverage has a different plan year	31 days following the Qualifying Event	Letter from the other plan documenting overlap or break in coverage	The employee may: ▪ enroll in coverage ▪ enroll eligible dependents ▪ change to single coverage ▪ discontinue coverage

Dependents who are full time students (age 19 but under age 26)	Full time student status must be received prior to coverage ending at age 19. If coverage is lapsed due to verification documentation being submitted late, the student may not be added until the following Open Enrollment.	Annual certification letter from the school's registrar along with a Dependent Status Information Form, including: ▪ enrollment dates for current and previous quarters or semesters ▪ number of credited hours per quarter or semester ▪ enrollment status for each quarter or semester (full or part-time)	
Disabled Child	During open enrollment you may apply to enroll an over-age disabled child not covered under SHBP prior to age 19 but who was disabled prior to age 26	▪ Medical documentation from the attending physician on the child's disability and the disability questionnaire to be completed by the employee. Call SHBP for the forms	Documentation must be received and approved by SHBP prior to coverage being granted

Event	Time Limitations	Required Documentation	Additional Information
Qualified Medical Child Support Order (QMCSO)	No time limit	Documentation of the court order and completion of membership form	The employee may: ▪ change to family coverage ▪ can change to any available option ▪ enroll in coverage
Loss of all eligible dependents	31 days following the Qualifying Event		The employee may: ▪ change from family to single coverage ▪ within 31 days of the loss of all eligible dependents

Procedure 60-U120:
Open Enrollment
Effective 07-01-2007

Open Enrollment

Active employees who are eligible to participate in the State Health Benefit Plan shall have an annual Open Enrollment period. The Open Enrollment period of time stipulated in which eligible employees of the group can choose a Health Plan alternative for the upcoming Plan Year. The Open Enrollment Period consists of a 15 to 30-day period beginning no earlier than October 1 and ending no later than November 15. Open Enrollment is a time each year active employees may enroll or change option or tier of coverage or discontinue, subject to the provisions of the Plan. Each year in advance of the period, the Commissioner of the Department of Community Health will announce the exact dates.

Note: Retirees may continue coverage at the time of retirement but are not allowed to enroll for coverage if they previously declined coverage at retirement.

Open Enrollment Period	Open Enrollment occurs every fall for the following plan year. Eligible Persons may enroll themselves and their Dependents	The SHBP determines the Open Enrollment Period. Coverage begins on the date identified by the SHBP
	Discontinue or change option or tier	The upcoming January 1
	Or make coverage changes during Open Enrollment	First of the month following request
	Or make coverage changes within 31 days of Qualifying Event	

Procedure 60-U250:
Continuing Coverage During Leave of Absence Without Pay
Effective 07-01-2007

Continuing Coverage During Leave of Absence Without Pay

Introduction

Employees covered by the State Health Benefit Plan (SHBP) who are on a leave of absence without pay (LWOP) are eligible to continue health benefit coverage during the period, for a maximum of 12 months, (military leave differs) if the LWOP has been approved by the appropriate organization official and is in compliance with one of the following definitions:

Unpaid Leave of Absence Definitions

Type Of Leave	Description
1. Disability Leave	For the purposes of continuing health benefit coverage, is the period of time for which the employee is totally disabled and has been granted an approved LWOP due to illness, accident, or disability
2. Reduced Working Hours	Is the period of time during an approved Disability Leave

Due to Partial Disability	when a licensed physician releases the employee to return to work on a part-time basis. The Employing Entity must approve the employee's return to work on a reduced working hours basis
3. Family Leave	Is the period of time, up to 12 weeks (26 weeks for Caregiver leave) during any 12 month period, during which an approved leave of absence with or without pay has been granted by the appropriate organization official
4. Educational Leave	Is the period of time during which an approved LWOP has been granted by the appropriate organization official for educational or training purposes
5. Voluntary Military Leave	Is the period of time during which an employee is on military duty other than an emergency activation
6. Emergency Activation Military Leave	Is the period of time for which the employee is activated to military duty on an emergency basis
7. Suspension or Other Leave or Absence	Is the period of time during which suspension is in effect or an approved LWOP
8. Employee's Convenience Leave	Is the period of time during which an approved period of LWOP is granted by the appropriate organization official and the Administrator for the convenience of the employee

Procedure 60-U150:
Unpaid Leave of Absence
Effective 07-01-2007

Unpaid Leave of Absence

Process

While your employee is out on Leave of Absence Without Pay it is your responsibility to keep track of your employee's leave status. Collection and remitting of health insurance premiums for employees who choose to continue health coverage while on Leave of Absence Without Pay will also be the responsibility of the employer. Leave Without Pay (LWOP) documentation will no longer be submitted to SHBP.

Procedure:

1. Each payroll location will responsible for collecting premiums from members on LWOP. The LWOP members will be reflected on the monthly bill. You no longer have to submit to SHBP the Forms Transmittal (for members that wish to continue their coverage while on LWOP) or members Disability Certification form. **BUT** you as the employer must keep on file any documentation approving the employee's LWOP by your location in the employee's file. These records must be kept for audit purposes. SHBP has the right to request copies of the documentation at anytime. If documentation can not be provided upon request, the employee's coverage will be terminated retroactively to their effective date of their Leave without Pay coverage and any claims that were paid by the Plan during this time will be the employee's responsibility, NO EXCEPTIONS.

2. SHBP will provide the payroll location a membership list, including option and tier that includes every covered active employee. This membership list will now include LWOP employees that are continuing to pay for their health coverage. A Forms Transmittal for an employee who is **not** paying for coverage while on LWOP will be necessary. All qualifying event information on the LWOP employee should be submitted to SHBP as you would an active employee. The payroll location will receive a bill including the amount to be paid to DCH. The bill will be based on the data in the MEMS system showing each enrolled member's option and tier.

3. The location will need to work with their own location HR systems to develop the procedures to track the LWOP employee and collect the appropriate health premium from LWOP employee that elect to continue health coverage. The payroll location will collect the appropriate premium and deposit that premium into the employer's account. The employer will submit the payment to SHBP as part if their normal monthly bill payment. SHBP will no longer accept payment directly from the LWOP member.

4. The payroll location must submit all qualifying event information to SHBP for LWOP members that continue to pay health insurance premiums using the same guidelines as for the active member. LWOP members will have access to the Open Enrollment web site just as any other active member.

Family Medical Leave Act for Military

The purpose of this policy is to define the new policy for Military "Called to Duty" and "Care Giver" of a Military service member. This new policy will change the form for LWOP. Two types of Leave will be added under Family Leave.

1. Documentation is required when a service member is called to duty for a period of 12 weeks. (A copy of the FMLA approval letter and copy of the orders)
2. On January 28, 2008, President Bush signed into law the National Defense Authorization Act for FY 2008, Section 585 of which amends the FMLA to allow two new types of leave for employees who are relatives of "service members." Under the first type of leave (qualifying exigency leave), an eligible employee is entitled to take up to 12 workweeks of leave during any 12-month period for a qualifying leave)" (as defined under regulations to be issued by the DOL) arising because the employee's spouse, son, daughter, or parent is on active duty (or has been notified of call or order to active duty) in the Armed Forces in support of a "contingency operation". (a specified military certification)
3. Documentation is required when a "care giver" of a service member is entitled to take leave. A FMLA approval letter
4. Under the second type of leave (service member care leave) an eligible employee who is the spouse, son, daughter, parent, or next of kin (i.e. nearest blood relative) of a covered service member is entitled to take up to 26 workweeks of leave during a 12-month period to care for the service member. A "covered service member" is a member of the Armed Forces (including the National Guard or Reserves) who is undergoing medical treatment, recuperation, or therapy, is an outpatient, or is on the temporary disability retired list, for a "serious injury or illness". (an injury or illness incurred in the line of duty on active duty in the Armed Forces that may render the service member medically unfit to perform his or her duties)
5. Rates will not change

Re-Enrolling a Member Returning From Leave Without Pay
For employees that do not continue to pay health insurance premiums while on LWOP:

Upon return from an approved leave of absence without pay, if the member remains eligible for health benefit coverage, the member must re-enroll for the same coverage option and type unless the member experienced a Qualifying Event for changing coverage outside the Open Enrollment period (see Procedure 60-U110 and Chapter 111-4-1-.06 in the Regulations of the Board). An employee who did not have health benefit coverage at the time he/she was placed on leave of absence cannot enroll upon return to work unless he/she experienced a Qualifying Event during the leave of absence without pay or the approved leave of absence included the annual Open Enrollment period. Time limitations and proper notification, as outlined in Procedure 60-U110, will apply.

An employee who receives donated leave during a period of approved leave without pay is considered to be on leave with pay during the donation period. The employer must resume SHBP reduction/deduction from the donated leave compensation and report the resumption of payroll deductions to the Plan. Refer to Procedure 60-U150.

Employing Entity Responsibility

Each Employing Entity has the responsibility to complete the Notification of Return from Leave Without Pay form (SHBP 66-093) and to resume the payroll deductions for the member's health benefit coverage. If an Open Enrollment period was missed by the employee while on leave of absence without pay, and the employee did not pay directly for health coverage, the Employing Entity should notify the employee of a special 31-day Open Enrollment period that begins with the first day the employee returns to work.

Note: If the member's earning in the month of return to work is sufficient for a deduction /reduction, must be taken to assure continuation of coverage.

SHBP Job Aid

Re-Enrolling a Member Returning From Leave Without Pay (Procedure 60-U150)

Procedure: for employees that do not continue health premiums while on LWOP:

1. Complete the Notification of Return from Leave Without Pay form to report the return to work of a member covered by the SHBP if the member returns to work during the same Plan Year in which the leave began and there was no qualifying event for a change of coverage while on leave without pay, the Notification of Return form Leave Without Pay form is the only requirement. The completed form should be forwarded to the SHBP in accordance with Procedure 60-U200. **If the employee is not enrolled in SHBP coverage, do not complete a Notification of Return from Leave Without Pay form.**

NOTE: If the employee was on leave without pay during an Open Enrollment period, and did not pay for coverage directly, the Employee should be given a 31-day special Open Enrollment period to make a change, such change will become effective the first of the month following the return to work (refer to Step 3 of this procedure for requirements.)

2. If the member files a request to change coverage or options because of a Qualifying Event during the leave of absence, the employee must complete a Membership Form (SHBP 60-090) and if employee has returned to work, the employer must complete the Notification of Return from Leave Without Pay form. Attach the 2 forms together and forward to SHBP in accordance with Procedure 60-U200.

3. If an Open Enrollment period was missed by the employee while on LWOP and he/she did not pay for coverage directly, the employee must be given a 31-day special Open Enrollment period that begins with the first day the employee returns to work as long a member did not pay directly while on leave without pay.

   a) When the employee elects to enroll or to change from coverage option and/or tier during this special Open Enrollment period, the employee must complete a Membership Form and the employer must complete the Notification of Return Leave Without Pay form. Attach the 2 forms together and forward to the SHBP an in accordance with Procedure 60-U200

   b) When the employee discontinues coverage during this special Open Enrollment period, the employee must complete a Discontinuation of Health Benefit Coverage form (SHBP 66-089). The copy of the form should be placed in the personnel/benefit file and the original forwarded to SHBP in accordance with Procedure 60-U200

NOTE: The Notification of Return from Leave Without Pay form should not be completed if the employee discontinues coverage.

Procedure 60-U160:
Transferring/Rehiring Members During Same Plan Year
Effective 07-01-2007

Transferring / Rehiring Members During Same Plan Year

Introduction

A transferring or rehired employee is any person beginning work for any eligible employing entity who previously worked for an eligible employing entity. This definition applies only if the employee transfers or is rehired within a Plan Year. An employee who ceased working for an employing entity during the previous Plan Year and who is being rehired by an eligible employing entity during the current Plan Year should be treated as a new employee as outlined in Procedure 60-U100 (Enrolling New Employees).

A member's signed SHBP Membership Form serves as a binding agreement for a Plan Year between SHBP and the member. The employee's election to enroll in one of the health benefit options or decline enrollment is made for the duration of the Plan Year. A change in the employing entity during the same Plan Year does not cancel the agreement nor change the conditions under which the member is enrolled. The former and current employers are both responsible for ensuring that the member is transferred with the same coverage option and type, and that all premiums are deducted and remitted in order to ensure continuous coverage.

Members transferring or being rehired from one eligible employing entity to another are **required** to keep the same coverage under the SHBP that they had in the previous employment, provided they still meet the eligibility requirements. Transferring members **may not** discontinue coverage or change their option or type coverage unless the transfer occurs at a point in time when the member could otherwise make a change Refer to Procedure 60-U110 (Enrollments/Changes in Coverage) for additional information. The member may change health benefit options only if they experience a Qualifying Event or move out of the service area of the option which he/she enrolled, during the transfer. A new Membership Form must be completed in order to reinstate coverage and to initiate billing for the coverage. This form should be submitted from the receiving (current) employer in accordance with Procedure 60-U220 (Processing and Submitting Health Benefit Forms).

The following applies for employees terminating employment and being rehired during the same Plan Year:

- If the employing entity participates in the State Personnel Administration Flexible Benefit Program, refer to the Flexible Benefit Program User's Guide for processing requirements

- If the employing entity does not participate in the State Personnel Administration Flexible Benefit Program, refer to procedure 60-U160 for processing requirements

Transferring employees not currently participating in SHBP **may not** enroll for coverage, unless they were ineligible before the transfer but become eligible due to the transfer. In the case

where an employee becomes newly eligible due to transfer, he/she should be treated as a new employee and provided a 31 day enrollment period. In this case, refer to Procedure 60-U100 (Enrolling New Employees) for processing requirements.

Employing Entity Responsibility

Each employing entity is responsible for coordinating the transfer of a member's health benefit coverage with the other employing entity. As soon as it is known that the employee will be transferring, the former and new employer should communicate the employee's participation status to SHBP. Timely communication is necessary to ensure continuation of the member's coverage and eliminate the need for administrative adjustments. The new employer will need to know the coverage option and type of health benefit coverage elected by the member and if the deduction for the coverage has been made for the month in which the transfer occurs. Potential problems may occur due to delays in communicating the information which may include:

- No salary deduction/reduction by the appropriate employer resulting in a lapse in the member's health benefit coverage
- Double salary deduction/reduction (former and new employer both made the deduction)
- Delays in processing or denial of member's medical claims

NOTE: If the new employer is not contacted by the former employer prior to the employee's first day of employment, the new employer should contact the former employer in order to obtain the information needed for continuation of the member's health benefit coverage.

The payroll deduction for health coverage under SHBP can be made during any pay period of the month. The former employer will normally be responsible for the payroll deduction for the month in which the member transfers.

- If the former employer cannot make the deduction due to insufficient salary, the receiving employer should make the deduction to ensure the member's continuous coverage
- If the transferring member has a break in employment of less than 30 days and health benefit coverage through the former employer is still in effect on the first date of employment with the new employer, the new employer should make a deduction in the first month of employment to ensure the member's continuous coverage
- If the transferring member has a break in employment and health benefit coverage through the former employer is no longer in effect on the first date of employment with the new employer, the new employer should make a deduction in the first full calendar month of employment. When a break in employment of more than 30 days occurs, a lapse in coverage will occur and retroactive premiums cannot be deducted to cover lapse period

- Overlapping Coverage. In the situation where the enrolled member has a period of overlapping coverage as a result of transferring employment between two separate employing entities, the coverage effective date with the second employer shall determine the coverage termination date with the first employer. The employing entity shall be responsible under this provision for deducting or refunding employee premiums as appropriate

- Dual Eligibility. In the situation where the enrolled member is eligible for coverage under SHBP as an active employee of two separate employing entities, the employee may, during the annual open enrollment period, elect which employing entity shall deduct the employee premium in the upcoming plan year. Each employing entity is responsible for remitting employer contribution amounts in accordance with 111-4-4-.02 (3)(d) in the regulations of the board

SHBP Job Aid

Transferring / Rehiring Members During the Same Plan Year
Former Employer
(Procedure 60-U160)

Step 1	Receive notification that the employee will be transferring to another eligible employing entity, review the employee's personnel file or other records to determine the coverage option and type of health care benefit coverage.
Step 2	Determine whether sufficient salary will be paid to allow the health benefit deduction/reduction, after any mandatory deductions.
Step 3	Notify the new/receiving employing entity of the coverage option and type in which the member is enrolled. Additionally, notify the new/receiving employing entity whether the health deduction will be made in the month of transfer by the former employing entity.
Step 4	Process the member's health benefit coverage termination as a "TRAN" in accordance with Procedure 60-U210. (Reporting Terminations of Coverage)

Transferring / Rehiring Members During the Same Plan Year
New /Receiving Employer
(Procedure 60-U160)

Step 1	Communicate with the former employer, prior to the employee's first day of employment, obtaining information necessary to setup the health benefit deduction/reduction in your payroll system. Specifically, the needed information includes the coverage option and type of health benefit coverage and whether the former employer has made the deduction for the month in which the member transfers. If the former employer has not made a current deduction, confirm the date of the last deduction and the date on which the coverage terminated.
Step 2	When the employee reports to work, have the member complete a new Membership Form. Remember, no changes in health benefits may be made by the member at this time unless the transfer occurs during the Open Enrollment period or the employee is otherwise eligible to make a change. Refer to Procedure 60-U110 (Enrollments/Changes in Coverage).
Step 3	Process the completed Membership Form in accordance with internal payroll procedures in order to establish the health benefit deduction/reduction in your payroll system. Unless otherwise instructed by the former employer , deduction/reduction should be handled as follows: ▪ If the member begins work on the first work day of the month, a deduction must be made during that month for the following month's coverage ▪ If the member begins work any day other than the first work day of the month, the former employer must make the deduction, provided the member earns sufficient salary to allow the health benefit deduction after any mandatory deductions ▪ If there is a break in employment and coverage through the former employer has already terminated on the day the member begins work, the first deduction is made in the first full calendar month of employment
Step 4	Submit the Membership Form in accordance with Procedure 60-U200 (Processing and Submitting Health Benefit Plan Forms).

Procedure 60-U170:
Processing Denied Actions
Effective 07-01-2007

Processing Denied Actions

Introduction

The Regulations of SHBP and federal regulations governing tax-qualified Cafeteria Plans require the health benefit coverage option and type elected by employees at the time of employment or during an Open Enrollment period be binding for the duration of the Plan Year. Enrollments and changes in coverage based on qualifying event conditions outlined in Procedure 60-U110 (Enrollments/Changes in Coverage) and Chapter 111-4-1-.06 in the Regulations of the Board are binding for the remainder of the current Plan Year. If a Qualifying Event does occur, the changes must be requested by the employee on a timely basis. **Changes not requested within the specified time frame will not be granted.**

Coverage actions that are not within the guidelines for allowing enrollments or changes outside the Open Enrollment period will be processed by the SHBP as Denied Actions. A notice will be produced for any Denied Action. The notice of the Denied Action will be mailed to the employee with a copy to the employing entity.

Employing Entity Responsibility

Each employing entity has the responsibility for adjusting their payroll records to ensure the correct deduction/reduction is being taken when a requested coverage action is denied. The employing entity should assist the employee in obtaining any documentation required to support the requested action.

If the requested action is denied because it does not fall within the guidelines for changing coverage outside the Open Enrollment period, the payroll records must be adjusted to reverse the submitted action and restore the employee to the previous coverage, if any. If remittance to the SHBP is based upon a erroneous deduction/reduction, the monthly billing statement will be out of balance until the adjustment is made; refer to Procedure 60-U220 (Processing the Monthly Billing Statement) for additional information.

If the action was denied pending receipt of additional information; the action may be resubmitted with the requested information. **Failure to submit the required information within 60 days of the date of the Denied Action notice will require the employee to wait until the next Open Enrollment period to make the change.**

SHBP Job Aid: Processing Denied Actions
(Procedure 60-U170)

Step 1	Receive copy of the Denied Action Notice that was mailed to the employee.
Step 2	Review the notice to determine the appropriate action to be taken. If the Denied Action is for one of the following reasons, a payroll adjustment should be made to reverse the submitted action and restore the employee to their previous coverage, if any. Once the payroll adjustment is made, no further action is required and you can proceed to STEP 3. An enrollment at any time other than initial enrollment, the annual Open Enrollment period, and before or within 31 days following the loss of the employee's spouse or enrolled dependent's group coverage. A change of coverage option at any time other than an Open Enrollment period, move from HMO service area, or a change in family status as defined in Procedure 60-U110. (Enrollments/Changes in Coverage) A change of coverage tier at any time other than an Open Enrollment period or a change in family status as defined in Procedure 60-U110. (Enrollments/Changes in Coverage) A change of coverage option or tier not requested within the time frames stated in the Regulations of the Board for the Qualifying Event to increase or decrease coverage. Refer to Procedure 60-U110. (Enrollments/Changes in Coverage) If the Denied Action is for one of the following reasons, additional information must be submitted by the employee for the SHBP to determine if the requested action meets the criteria for a change outside the Open Enrollment period. If the requested information is not received by the SHBP within 60 days of the Denied Action notice, the requested action will not be allowed until the Open Enrollment period and an adjustment to the payroll deduction/reduction will be requested. A request to enroll or change coverage will be denied if it does not include a letter from the employee's, spouse's or former spouse's employer, Medicaid or Medicare giving reason for termination or coverage and the date of termination of the other group health coverage. The letter needs to be on the organization's letterhead, signed by an official and include a telephone number. A Certificate of Creditable Coverage from another group health plan does not provide the information required to process the requested change in coverage.
Step 3	Verify that the employee received the denied action notice, and if additional documentation is required, assist the employee in obtaining and submitting the documentation within the time limit. Inform the employee that the salary deduction/reduction has been restored to the previous coverage, if any.

Procedure 60-U180:
Processing a Membership/ Dependent & Miscellaneous Update Form
Effective 07-01-2007

Processing a Change Miscellaneous Update Form

Introduction

A change in a member's/dependent's name or a change of certain other information concerning the member or dependent must be reported on the appropriate SHBP form, regardless of the option or coverage tier in which the member is enrolled. Miscellaneous data updates that do not entail a change of premium, a change of name, or a change of Social Security number may be reported by the member directly to the SHBP or, at the employing entity direction, may be submitted in accordance with this procedure. If the employing entity chooses to have the member report miscellaneous data updates directly, the member should be supplied with the appropriate form (66-090). The member should also be supplied with the address to which the form is to be sent.

State Health Benefit Plan
PO Box 1990
Atlanta, GA 30301-1990

or faxed to:
State Health Benefit Plan
866-828-4796

Employing Entity Responsibility

Each employing entity should encourage members to update certain information to the SHBP and should furnish the member with the appropriate form(s). Accurate membership records for members and dependents are required for processing of claim payments and/or verification of coverage to providers of medical services.

SHBP Job Aid: Completing a Membership / Dependent and Miscellaneous Update Form (Procedure 60-U180)

Step 1	Receive a request from a member to report one or more of the following changes: a) Name b) Address or telephone number c) Adding or deleting a dependent (WILL NOT change coverage type from single to family or family to single coverage) NOTE: In certain instances the acquisition of a dependent or the loss of an only enrolled dependent may create eligibility for a change of coverage. Refer to the back of the Change and Miscellaneous Update Form (SHBP 66-090) to determine if other documentation is required. d) Social Security Number e) Update for dependent student status

Step 2 **Section I:** **Section III:** **Section IV:** **Section V:** **Section VI:** **Section VII:** **Section VIII:**	If the member is requesting a name change, address or telephone number change, Social Security number update, or adding or deleting (but not a change in coverage), have the member complete a Change and Miscellaneous Update form (SHBP-66-090). For update of student status, proceed to Step 3. The member should complete the Change and Miscellaneous Update form as follows: Complete this section with name, Social Security number, current address, and telephone number Member should check the appropriate box in this section to identify the type of change/update being requested. Some changes require other documentation. Member should indicate the date of the event that triggered this request The employee should mark the coverage option selected The employee should answer the tobacco and spousal surcharge questions The employee should select the appropriate coverage tier The member should complete all information in this section, i.e., new dependents should be listed if the member is already enrolled for family coverage, and documentation should be submitted if required. Refer to the "Eligible Dependents" section on the back of the form for required documentation. The relationship of each new dependent to the member must be identified using one of the codes listed on the form. If more than four dependents need to be listed, use a second Change and Miscellaneous Update Form (SHBP 66-090) and staple that form to the first form The member should carefully read the terms and conditions before signing and dating the completed form
Step 3	If the member is updating a dependent's student status, have the member complete the Dependent Student Status Information form (SHBP 66-082). All information on this form must be updated with the SHBP annually in order for the member to maintain a valid SHBP identification card with the dependent child's student status correctly described. This form may be submitted directly to the SHBP by the member at the address on the form.
Step 4	Review the form(s) for proper completion and complete Section II of the Change and Miscellaneous Update Form (SHBP 66-090) by indicating the Department/School System Number and Unit/School Code for employing entity.
Step 5	Complete the top portion of the Forms Transmittal Sheet by writing:

	a) The department, agency, or educational institution's five-digit Payroll Location Number The use of an incorrect number will result in delay of coverage or incorrect billing and will require additional documentation to correct b) The Payroll Location name c) The name of the person submitting the report d) The telephone number of the person submitting the report e) The submission date of these transactions
Step 6	Mail the batch of documents to the SHBP, Eligibility Section, at the address in the upper right corner of the Forms Transmittal Sheet.

Processing and Submitting State Health Benefit Plan Forms

Introduction

Prompt reporting of membership transactions is essential to the maintenance of accurate member coverage records and employing entity billing records. Specific deadlines have been established for submission of all actions (forms and terminations) to the DCH. These deadlines ensure that all actions transmitted will be processed before running the monthly billing statement. Prompt submission ensures correct verification of coverage and benefit payments to medical providers. Prompt submission also limits the financial hardship of a member held responsible for repayment of SHBP benefits issued after the coverage should have ended.

The Membership Enrollment Management System (MEMS) is designed to allow employers to transmit all types of actions before the effective date of the action by indicating the payroll period or the first or last deduction/reduction period. The deduction date allows MEMS to calculate the correct coverage effective date.

Employers are encouraged to transmit the action as soon as the action is known. For example, employees hired on the first workday of the month must complete the Membership Form before the end of that month for a premium deduction/reduction to be taken in the month preceding the effective date of coverage. As soon as the form is completed, it should be forwarded to SHBP in accordance with this procedure.

Reporting a termination as a result of retirement that overlaps an Open Enrollment period should be delayed until the day following the deadline for Open Enrollment processing. That date can be found in the Open Enrollment Guide.

1. Employers should submit all transactions, regardless of the effective date, by the 15th of the month in which the first deduction/reduction (enrollments and other changes) are to be made or the 10th of the month following the last payroll deduction/reduction (terminations)

2. Large employers should submit SHBP forms more than once a month. The number of submissions is at the employer's discretion; however, all submissions should be made by

the date specified above and should include all actions affecting coverage on the first of the next month

3. All transmissions to the SHBP must be accompanied by a Forms Transmittal Sheet (SHBP 60-010)

Employing Entity Responsibility

The employing entity is responsible for promptly submitting all transactions to the SHBP. Failure to report promptly can result in the delay of health coverage verification of member benefit payments which can increase the financial liability of both the member and the Plan.

The employing entity is required to report a member's last date of payroll deduction and reason for coverage termination no later than 30 days following employment termination or loss of eligibility to participate through payroll deduction/reduction. Any penalties assessed SHBP for failure to comply with timely notification requirements of federal COBRA legislation shall be billed to the responsible employing entity. Refer to Procedure 60-U210 and Chapter 111-4-1-.13, Duties and Responsibilities of Employing Entity.

The employing entity is also responsible for verifying that all transactions submitted to the SHBP are processed. The reconciliation process must be accomplished each month when the Monthly Billing Statement is received. In the event the previously submitted transmissions are not processed by the SHBP, contact your Employer Services representative at 800-610-1863.

Job Aid: Processing and Submitting State Health Benefit Plan Forms

(Procedure 60-U200)

Step 1	Review all Forms, Membership/Dependent and Miscellaneous Update Form (SHBP 66-090); Declination of Health Benefit Coverage, Notification of Return from Leave Without Pay, and Discontinuation of Health Benefit Coverage forms. Ensure that the second copy of those forms that have multiple copies have been removed and retained. It's recommended that these forms be held in a pending file until the monthly billing statement is received and processed. After receipt of the monthly billing statement, verify the Plan has correctly processed the transaction and place the second copy in the employee's permanent personnel or benefit file.
Step 2	Count the number of each type of form being submitted. Record this number in the appropriate space on the Forms Transmittal Sheet (SHBP 66-010).
Step 3	Attach the original forms to the Forms Transmittal Sheet. Retain copies for reconciliation with the Monthly Billing Statement.
Step 4	List any terminations of coverage on the Forms Transmittal Sheet. Refer to Procedure 60-U210.
Step 5	Complete the top portion of the Forms Transmittal Sheet by writing:

	a) The department, agency, or educational institution's five-digit Payroll Location Number. The use of an incorrect number will result in delay of coverage or incorrect billing and will require additional documentation to correct b) The Payroll Location name c) The name of the person submitting the report d) The telephone number of the person submitting the report e) The submission date of these transactions
Step 6	Mail the batch of documents to the SHBP, Eligibility Section, at the address in the upper right corner of the Forms Transmittal Sheet.

Procedure 60-U210
Reporting Terminations of Coverage
Effective 07-01-2007

Reporting Terminations of Coverage

Introduction

Prompt reporting of employee terminations is essential to the maintenance of accurate employee coverage records and department billing records. See Chapter 111-4-1-.09 of the Regulations of the Board. Further, Federal legislation mandates that employees who are no longer participating in the State Health Benefit Plan (SHBP) through payroll deduction be notified of eligibility to extend coverage under COBRA. Notification generated to the employee by the SHBP is based on the termination code and the last payroll deduction date reported by the Employing Entity. Failure of the Employing Entity to notify the SHBP on a timely basis of a termination of coverage may subject the SHBP to penalties by the Federal government. Any penalties assessed for failure to comply with the notification requirement because of the Employing Entity's failure to notify the SHBP will be billed to the respective Employing Entity.

A payroll deduction for health coverage must be made from salary earned during a month as long as the covered employee receives salary sufficient to support the required deduction after mandatory deductions are made. The employee's coverage will terminate at the end of the month following the month in which the last payroll deduction is made**. If an employee is receiving only terminal pay in a month, the health benefit coverage deduction should not be made.**

Employing Entity Responsibility

Each Employing Entity must submit coverage termination within 31 days prior to or following employment termination or loss of eligibility to participate in the Health Plan through payroll deduction/reduction. Delayed reporting of termination of coverage will cause over-billing to the Payroll Location. Adjustments to the monthly billing report must be made and documented when termination reporting is delayed. Delayed reporting can also result in payment of claims on behalf of members who are no longer eligible to receive benefits. Recovery of payment made on behalf of inactive members causes increased expense to the SHBP, thereby contributing to escalating costs for the members and department, agencies and educational institutions.

SHBP Job Aid

Reporting Terminations of Coverage

(Procedure 60-U210)

1. Determine that an employee will not have continued payroll deductions/reductions for health benefit coverage.

2. List the employee on the Forms Transmittal (SHBP 66-010).

   a) Write the appropriate termination code

   b) List employee's Social Security number, name, and date of last payroll deduction

   Note: If the listing is for an employee for whom no payroll deduction has been made, or a new employee who failed to work on the effective date of coverage, write "NONE" in the "date of last payroll deduction." Attach documentation explaining the circumstances for this action.

3. Complete the top portion of the Forms Transmittal Sheet by filing in:

   a) The Employing Entity five-digit payroll location number

   b) The Payroll Location name

   c) The name of the person submitting the report

   d) The telephone number of the person submitting the report

   e) The submission date for the forms batch

4. Count the number of terminations listed and write this number in the column to the right of "Termination (listed below)" under the Transaction Reported header.

5. Complete the Transaction Report count for other types of transactions you are attaching to the Forms Transmittal Sheet.

6. Retain a copy of the Forms Transmittal Sheet for verification and mail the original form to the address shown in the upper right corner of the form.

Termination Codes

Code	Description
TERM	Termination: the employee is no longer employed by the Employing Entity. Future employment with another employer participating in the SHBP is not indicated
TRAN	Transfer: the employee is no longer employed by the Employing Entity, but has indicated future employment with another participating Employing Entity. If in doubt as to whether an individual is transferring to another participating Employing Entity, report the transaction as termination
DISC	Discontinue coverage: the employee has experienced a Qualifying Event that allows the employee to voluntarily discontinue coverage outside the annual Open Enrollment Period although still employed. A timely Discontinuation of Health Benefit Coverage form (SHBP 66-089) must be completed by the employee and submitted with the Forms Transmittal Sheet This action must be listed on the Forms Transmittal Sheet in order to terminate coverage and cancel billing Documentation of the qualifying event is required During the Open Enrollment Period, an employee may voluntarily discontinue coverage with the Health Plan although still employed. Follow instructions in the annual Open Enrollment Guide regarding processing of Open Enrollment discontinuations of coverage.
LWOP	Leave Without Pay: The employee is no longer receiving compensation but has been granted an approved leave of absence without pay or has been temporarily suspended without pay from normal duties and will miss a health deduction
RETR	Retirement: The employee is no long actively employed by the employing Entity due to retirement **Note: Local school systems that continue to pay a teacher or public school employee for the summer months, even though the person is retiring effective in June or July, take the last deduction from the month the employee last worked (most likely the month of May).**
LOFF	Laid Off: The employee is laid off due to a reduction in force
DCSD	Death: The employee is deceased
RHRS	Reduction in Hours: the employee continues employment under the definition of employee; however, he/she no longer works the required number of hours to be eligible for health benefit coverage

Procedure 60-U220:
Processing the Monthly Billing Statement
Effective 07-01-2007

Processing the Monthly Billing Statement

Introduction

Each employing entity that is authorized by law to participate in the SHBP administered by the Board of Community Health has the responsibility to accurately report information regarding employees who are eligible for and covered by the SHBP. The SHBP has been delegated the responsibility for defining the administrative practices for maintaining eligibility records and collecting the monies due from each employing entity. Failure to remit funds and/or transmit eligibility information can place coverage for the specific entity's employees in jeopardy.

The eligibility information creates the records for the monthly billing statement. Upon receipt of the monthly statement, the employing entities are responsible for verifying and correcting, if necessary, the eligibility records as shown on the billing statement.

Monthly Billing Reports

Monthly billing information is transmitted back to the employing entity via monthly reports. Authorized employing entities may access their monthly billing reports electronically for viewing and/or printing on the SHBP View Direct System. In order to view daily transactions the view direct system also has available a "proof bill" (not to be used for payment purposes).

A SHBP View Direct Access Agreement/View Direct Payroll Location Agreement must be completed by the employing entity. This agreement gives access to the secure site where payroll locations can retrieve reports. Each location may be assigned up to three login IDs and passwords. These logins are assigned to specific individuals within the Payroll Location. Each individual must sign an agreement that they will not allow ANYONE access to their login ID or password. The manager will also have to sign an agreement that he/she will immediately advise the Employer Services Unit of SHBP at 800-776-9045 or 404-651-6131 to terminate login and password if an assigned user is no longer eligible to view reports. SHBP will also provide detailed instructions regarding the viewing and retrieval of available reports upon the completion of the access agreement.

The total premium amount and the employer contribution (or administrative fee) must be transmitted by the **fifth working day of the month.**

SHBP Job Aid

Accessing the Secure Web Site for the Monthly Billing Statement

(Procedure 60-U220)

Step 1	From the Internet go to Web site: **http://ebill2.gagta.com** Please note: there is no www before the site address
Step 2	The secure Web site sign in page will be displayed. There are two sign in areas - sign in at: **SSG Info User ID** • **Enter** your individual sign in **ID** and tab to the password • **Enter** your individual **Password** • **Click - Sign In** (Pressing the Enter key on your keyboard does not work)
Step 3	This **GTA Electronic Billing Service Page** contain the correct billing reports will be displayed. *Note:* *Under the Sign In there is a space to change your password. The password must be changed every 60 days. The system will generate a reminder 20 days before the password is due to expire. You must be in View Direct to see the reminder. Once you change your password, it will update overnight and the new password can be used the next day.*
Step 4	There are three buttons at the top left side of the **GTA Electronic Billing Service Page**. **It is not necessary to use these buttons from this page.** They are: 1. File folder button = Open 2. Paper with magnifying glass button = Locate 3. ? Button = Help (Please note that all buttons available in the help section are not available in the state system **Under these buttons are reports you can access through View Direct.** To select a report: • **Click** on a **report name** from the listing • A list of monthly reports will be displayed

SHBP Job Aid

RETRIEVING AND PRINTING MONTHLY BILLING STATEMENT
(Procedure 60-U220)

1. When you click on a report it will open up with a list of the specific monthly report(s) that you can view

2. Next to the monthly report it will say **Recall Required or Available:**

    - If Recall is required - You click on the report to order and check back later to get the report
    - If Available - You click on the report and it will come up on your screen

There are several buttons on the report. Each button has a description when you put your cursor on it. You will use these buttons to locate specific information.

1. Previous Page button - This button is used when you are in a report and need to back up
2. Next page button - Is used to page down through the report

3. Print button - Is used to print the entire report. If you have more than one Payroll Location, this button will print all of the locations. If you need to print the location you are looking at, you can select the current report from your print page. The printing default is in letter format and you will want to change this to landscape before printing your reports. (Note: you must access this Web page through Internet Explorer to be able to print View Direct documents)

4. Print current page button - Prints current page only

5. Down Load button - You may want to down-load your report to your PC rather than print

6. Page Notes button - You can go into this section and make a note. This note can be viewed by anyone who has access to this report. The report will track who made the comment

7. Search button - Use this button when you are searching for a specific person. Be sure you are going in the correct direction when you are searching. Example: If you just looked up Williams and now want to look up Smith, you will want to be sure the search is going up, not down the report, since Smith comes before Williams

If you need additional help contact the Employer Services Unit at 800-776-9045 or 404-651-6131.

SHBP Job Aid

Monthly Billing Reports Description
(Procedure 60-U220)

Report Name/Report Number	Report Description
Transaction List (Report 360-H141)	**The primary purpose of the Transaction List is to report to the entity those actions that were processed by the SHBP during the month and/or have been processed for a future effective date.** The Transaction List has three major categories: Retroactive Actions, Current Actions, and Pending Actions. When actions are listed, the employee's name, Social Security number, coverage option and type, coverage effective date, and a notation of the type of action will be displayed. The number of pages of the H141 report is determined by the number of coverage actions processed during the month. All transactions are listed alphabetically by the member's name. a) **Retroactive Actions**: Each coverage action that was processed since the last billing statement that has an effective coverage date prior to the effective date of the current month's statement is listed in the section b) **Current Actions**: Each coverage action that has the same effective date as the current month's statement, regardless of when the action was processed, is listed in the section. Current actions will include prior month's pending actions which now have a current effective date c) **Pending Actions**: Each coverage action that has a future effective date is listed in the section. Pending actions will continue to be listed on subsequent statements until the effective date is reached and the actions become current actions
Reported Membership Totals (Report 360-H142)	**The primary purpose of the Reported Membership Total is to display the total number of current members and the calculated current month's premium deductions due for each option and coverage type.** Only options and coverage in which members are currently enrolled will be listed. **NOTE: A coverage change is listed as a decrease in the old coverage and an increase in the new coverage. For example, a change from OAP Single Coverage to OAP Family Coverage will be displayed as a decrease of "1" on the column and row for OAP Single Coverage and as an increase of "1" in the column and**

	row for OAP Family Coverage. The column headings on the Report Membership Total report are explained as follows: 1) **Column A:** "Previous Reported Totals" displays the total number of members that were reported in Column G of the previous month's Report Membership Totals report
	2) **Columns B and C:** "Retroactive Actions" displays the total number of actions (increases and decreases) that had an effective date earlier that the current billing month, and that were reported and have been processed since the last billing statement was produced. These numbers should be the total number of actions listed in the "Retroactive" section of the H141 3) **Column D:** "Adjusted Previous Totals" displays the number of members enrolled in each option and coverage type before the current month's activity is added The number is calculated by adding across rows in Columns A and B, less Column C 4) **Columns E and F:** "Current Actions" displays the number of increases and decreases in members in each option and coverage type for actions that are effective in the same date as the billing statement. Some of these actions may have been submitted in prior months. These numbers should coincide with the total number of actions listed in the "Current" section of the H141 5) **Column G:** "Reported Current Totals" displays the number of members enrolled in each option and coverage type for the billing statement effective date The number is calculated by adding across rows in Columns D and E, less Column F If all actions were transmitted to the SHBP is sufficient time for processing, the total by option/coverage type should agree with the total number of employees that your payroll records reflect as being enrolled 6) **Column H:** "Deductions Due for this Month" displays the calculated total deduction amount due for the current month's billing statement. The dollar amount displayed is the number in Column G multiplied by the deduction rate for the current month
Retroactive Reported Adjustments	**The primary purpose of the Retroactive Reported Adjustments report is to display the premium amount calculation for all**

(Report 360-H143)	**reported, retroactive transactions that were processed since the previous month's billing statement.** 1) **Column A:** "Coverage Months" lists a row for each of the three months immediately prior to the current billing statement month. Retroactive actions with effective dates earlier than the three listed months are reflected in the row labeled "Other"
Report Name / Report Number	**Report Description**
	2) **Columns B and C:** "Reported Changes" displays the number of retroactive membership actions (increases and decreases) that were processed for effective dates earlier than the current statement month 3) **Column D:** "Net Changes" displays the net number of retroactive actions after the increases or decreases are accumulated for each of the months shown 4) **Column E:** "Rates" is a premium deduction dollar amount multiplied by the months for which the action is retroactive If the retroactive coverage date and the billing statement date span the effective date of a change in premium, the change in premium will be reflected 5) **Column F:** "Extensions" is the product of the "Rates" (Column E) times the "Net Changes" (Column D). If the retroactive coverage date and the billing statement date span the effective date of a change in premium, the change in premium will be reflected 6) **Column G:** "Net Amount of Changes" is the subtotal of amounts shown in Column F, for each option and coverage type. The bottom row on the report represents the grand total of all deductions due for actions with an effective date prior to the current billing month. This month will be reflected on the H145 on line 2
Adjustments Work Sheet (Report 360-H144)	**The H144 is a formatted report and has the primary purpose of allowing the employing entity to document the adjustments that are required to reconcile the billed amounts to the actual deducted premium amounts for your employees** If all transactions submitted have been verified and the premium amounts that were deducted for those who are enrolled balance with the amount billed by the SHBP, this formatted report is not needed and should not be returned to the SHBP If the premium amounts deducted for the

	employee salary differ from the SHBP's billed amount or the transactions submitted cannot be verified, the worksheet should be completed as a tool to reconcile employee coverage records. All forms should be forwarded; H144 does not correct coverage
Statement (Report 360-H145)	The primary purpose of the statement report is to display the calculated amounts due for the employee's premium deductions and to reflect amount**s** paid since the last billing statement. This report also provides information regarding the employer's contribution or administrative fee amount, and a space to itemize the checks to be transmitted to the SHBP for the monthly payment amounts. Each line is explained as follows: a) **Line 1:** Displays the amount billed (+ or – line 6) for the prior month
Report Name / Report Number	**Report Description**
	b) **Line 2:** Displays the amount calculated (positive or negative on the Retroactive Reported Adjustments H143 a) **Line 3:** Displays the sum of lines 1 and 2, which is the adjusted employee deduction amount due for the prior month b) **Line 4:** Displays the employee deduction payments received and posted to SHBP accounting records through the date shown c) **Line 5:** Displays special accounting adjustments processed by the SHBP d) **Line 6:** Displays the sum of lines 3, 4 and 5, and represents the outstanding employee deduction amount due for prior billing months e) **Line 7:** Displays the employee deduction due for the current month's enrollment only. This amount is carried forward from Reported Membership Totals (H142) f) **Line 8:** Is provided to record the total value of the employee deduction amounts due for any adjustments. Any amount shown on this line MUST be itemized as an adjustment on the Adjustment Work Sheet (H144) and supporting documentation for the adjustment MUST be attached. If supporting documentation cannot be attached, no adjustment can be entered on line 8 and the employee

	premium deduction billed must be remitted g) **Line 9:** Is provided to list the sum of lines 7 and 8 h) **Line 10:** Is provided to list the sum of lines 6 and 9. This is the total amount due for employee premium deductions NOTE: The lower one-third of the Statement report is to list the amount due from the employer contribution for health benefits and to itemize the checks/payments transmitted.

Job Aid:

PROCESSING THE BILLING STATEMENT

(Procedure 60-U220)

	Action
Step 1	Retrieve the monthly billing statement from View Direct. Review the documents to ensure that Reports **360-H141, H142, H143, H144 and H145** are present and then print A Membership List may be accessed via View Direct
Step 2	Verify from the Reported Membership Adjustments (H142) that the **total number of covered members is correct**. Contact the Employer Service representative of SHBP if you need assistance in reconciling the numbers or premium calculations
Step 3	Verify that the Retroactive Reported Adjustments (H143) correctly **reflect all reported and processed transactions with an effective date earlier than the statement effective date**
Step 4	**Document any adjustments** to the employee premium deduction amount on the Adjustment Worksheet (H144) a) List the social security number and name of the member b) List the "old" coverage of the member. List "NONE" if no prior coverage c) List the transaction type (enrollment, transfer, return from LWOP, change option, change coverage type, or any of the termination types listed on the Forms Transmittal Sheet d) List the "new" coverage of the member. List "NONE" if the transaction is one of the termination types e) List the effective date (not first deduction date or last deduction date) of the new coverage or termination. New coverage is always effective the first day of the month and coverage termination is always effective the

	last day of the month. f) Calculate the employee premium deduction amount of the adjustment. Multiply the monthly deduction amount by the number of months for which the adjustment is being reported g) Calculate the net adjustment of all transactions listed on the report Write the amount in the block on the bottom row of the report
Step 5	Complete the process of reconciling the billing Statement (H145) for the **employee deduction amounts due.** a) On line 8 of the Statement, list the amount calculated for the net adjustment on the Adjustment Worksheet (H144) only if supporting documentation for each line item is attached to the worksheet. If supporting documentation is not attached to the H144, no adjustment can be entered on line 8 b) Add lines 7 and 8 and record the total in both spaces provided on line 9. Add lines 6 and 9 and record the total employee deduction amount due on line 10 If the sum of these lines does not agree with the amount you have payroll deducted, or should have deducted, you must proceed to step 5c If the sum of these lines agrees with the amount deducted, proceed to step 6
	Action
	c) Resolve any outstanding employee deduction amount listed on line 6. If this amount cannot be identified and reconciled, contact the SHBP Employer Services representatives for guidance d) For State agencies and others who share payroll data with the SHBP, utilize the MEMS/Payroll Deduction Comparison Report (H144) to identify potential health benefit record errors and to reconcile health benefit membership and accounting records to SHBP records For each exception category, compare the payroll deduction records with the coverage record on the SHBP membership list report (H144) Adjust as necessary for any differences in coverage or deduction amount on the Adjustment Worksheet Calculate the **employer contribution**: a) State Departments, County Departments of Family and Children

	Services, Technical Schools and Departments of Health should enter total salaries in the space labeled “Total Personal Services for (Month)” Multiply this amount by the employer rate shown on the Statement and enter the Amount Due for Employer Contributions in the space provided b) School Systems should enter the total state-based salary amount for certified personnel and record the amount in the space labeled “Total Personal Services for (Month)” Include all persons serving in a certified capacity, **including those positions not participating in the SHBP**. Multiply the calculated salary amount times the employer rate shown on the Statement and enter the Amount Due for Employer Contributions in the space provided

	c) Schools Systems should **enter the contribution amount for school service personnel based on the total number of employees enrolled, regardless of the type of coverage selected by the employee.** The contribution amount that has been calculated and is shown on the statement is based on the SHBP membership records Pay the "Total" amount indicated unless adjustments are required Adjustments for deductions must be reported on the Adjustment Worksheet as described in step 5. Adjusted contribution amounts should be documented on the Statement in the space provided d) Community Service Boards and Regional and Community Libraries must multiply the dollar amount for Total Services (exclusive of per diem and casual labor) times the Employer Rate shown on the Statement and enter the Amount Due for Employer Contributions in the space provided **NOTE: School Systems, Libraries, and Community Service Boards must submit a copy of the total pages from their payroll summary report. In addition to the payroll summary report, documentation must be submitted to substantiate hours worked for all Temporary/Casual Labor which includes amounts paid for employees occupying positions established for less than nine months or scheduled for less than 30 hours per week These positions are <u>not</u> eligible for other optional benefits The SHBP Accounting Divisions will contact you if the required payroll information is not included for the specified entities. <u>This could result in a delay in posting payments.</u>** Employing entities that wire funds directly to the Plan or through the Office of Treasury and Fiscal Services are still required to submit the documents as stipulated above. The documents must be mailed to: **State Health Benefit Plan** **2 Peachtree Street, NW** **34th Floor** **Atlanta, GA 30303** *or faxed to:* **State Health Benefit Plan, (404) 657-9896**

Procedure 60-U230:
CREDITABLE COVERAGE
Effective 07-01-2007

Creditable Coverage

SHBP members and dependents can reduce or eliminate the 12-month Pre-existing Condition (PEC) limitation period by documenting "creditable coverage." Creditable Coverage generally includes the health coverage a member or a dependent had immediately before joining the SHBP. Coverage under most group health plans; individual health policies and some governmental health programs qualify as creditable coverage.

To reduce or eliminate the PEC limitation period for members coverage:

- Provide the SHBP with a certificate of creditable coverage from one or more former health plans or insurers that states when prior coverage started and ended
- Any period of prior coverage under a qualifying plan will offset the 12-month PEC limitation period if the time between losing coverage and the first day of SHBP does not exceed 63 days
- If enrolling as a new hire, the 63-day period is measured from the last day of prior coverage up to the hire date

To reduce or eliminate the PEC limitation period for dependents:

- Provide the SHBP with a Plan – approved certificate of creditable coverage stating when prior coverage started and ended for each dependent that the member wants to cover
- Any period of prior coverage under a qualifying plan will offset the 12-month PEC limitation period if no more than 63 days have elapsed between the dependent's loss of prior coverage and the first day of coverage under the SHBP (or hire date, if enrolling as a new hire)

If the member or a dependent had any break in former coverage lasting more than 63 days, they will receive creditable coverage only for the period of time after the break ended.

Obtaining a Certificate of Creditable Coverage

Within two years after the former coverage terminates, members have the right to obtain a certificate of creditable coverage from the former health plan(s) to offset the PEC limitation period under the SHBP. After completing an evaluation of the certificate of creditable coverage or other documentation, the SHBP will notify the member as to how the PEC limitation period will be reduced or eliminated.

Procedure 60-U240:
Providing Information Upon Termination or Retirement (COBRA):
Effective 07-01-2007

PROVIDING INFORMATION UPON TERMINATION OR RETIREMENT (Consolidated Omnibus Reconciliation Act)

Introduction

Upon termination of employment for any reason, other than gross misconduct, a member has the option of continuing health benefit coverage under the SHBP. Dependents that cease to be eligible on a member's coverage are eligible to continue under the COBRA provision. There are different provisions under which members may continue their coverage. Eligibility will be in accordance with the Regulations of the Board of Community Health that are summarized in this procedure.

Note: If a member withdraws his/her money from a State of Georgia retirement system in lump sum, the employee loses eligibility for continuation of coverage except through the COBRA provision for temporary extended coverage.

Termination/Retirement Definition

1. Retirement: A member who terminates employment due to retirement may continue health benefit coverage by having the retirement system deduct the monthly health benefit coverage premium from his/her monthly retirement annuity. If the retiring employee will receive a monthly annuity, but the annuity will not be in an amount sufficient to deduct the premium; health coverage may be continued by paying a monthly premium directly to the SHBP. If the retiring employee will not receive any monthly annuity, continuation is limited to the extended beneficiary provisions of COBRA that are listed below. A terminated employee may also qualify to continue coverage under the resignation provision (see below).

2. Pending retirement: Member who has applied for service retirement may pay directly to the SHBP for the period between termination of coverage as an active employee and the effective date of coverage as a retiree. There must be a reasonable expectation that the employee is eligible for retirement except for completion of the administration processing to begin a retirement benefit payment.

   Continuation under this provision may not exceed six months. If a Board of Trustees or retirement administrator has not rendered a decision on a pending request after six months or if a retirement request is denied for immediate onset of annuity payments, the terminated member will no longer be eligible to continue coverage under this provision. At that point,

continuation would be limited to the extended beneficiary provisions of COBRA for a maximum of 18 months **inclusive** of any months of coverage extended through the pending retirement provision.

3. State employee who resigns: A state employee who resigns or Official fails to be re-elected, or who does not seek re-election to office and who has completed eight or more years of service may continue full coverage and participation by payment of a monthly premium. A request to continue this coverage must be mailed to SHBP within 60 days following coverage termination as an active employee along with an affidavit from the Employing Entity or retirement system certifying the length of service. The state employee must pay both the employer and employee premiums for such coverage. The premium must be paid within 30 days of receipt of a notice of premium date.

   Note: The provision can take effect at the end of the expiration of the extended beneficiary provision of COBRA.

4. Teacher or public school employee who resigns or retires: A teacher or public school employee who resigns or retires with eight or more years of creditable service in one of the eligible retirement systems may continue full coverage and participation by payment of a monthly premium.

   A request to continue this coverage must be mailed to SHBP within sixty (60) days following coverage termination as an active employee along with an affidavit from the retirement system certifying the length of service and when annuity is expected to be received. The employee must pay both the employer and employee premium for such coverage. The premium must be paid within 30 days of receipt of a notice of premium date.

   Note: This provision can take effect at the end of the expiration of the extended beneficiary provision of COBRA.

5. Any person who ceases to be eligible for coverage: COBRA provides that a worker (active or retired) and his/her dependents who are covered by a health care plan, will be entitled to temporary extended coverage under that plan whenever the member's coverage ends because of loss of eligibility. A member's loss of eligibility can be triggered by resignation, termination, layoff, or reduction of working hours. The eligibility of covered dependents can end if the member's eligibility ends or due to divorce or death. Also, the eligibility of a covered dependent can end for other reasons, such as age limitation or loss of student status. If a member's eligibility ends, thereby automatically ending eligibility for all of his/her covered dependents, the maximum period of temporary extended coverage under COBRA will be 18 months. If a member's coverage stays in effect, but the dependent's eligibility ends, the maximum period temporary extended coverage for that dependent under COBRA will be 36 months.

SHBP Job Aid:

Providing Information upon Termination or Retirement

(Procedure 60-U240)

1. Receive notification of a member's retirement, termination, or reduction in hours

2. Advise the member of the options available for continuation of health benefit coverage and of the action required to continue that option, as indicated below:

   a) **Retirement:** Retirees whose annuities are administered by the Teachers Retirement System (TRS), Employees Retirement System (ERS), Public School Retirement System (PSERS) will no longer have to complete a Retiree/Surviving Spouse Form to Continue coverage as a retiree

   The process below should be followed for the retiree/surviving spouse continuing health coverage with SHBP

   - A file of retirees receiving their first retirement check will be sent to SHBP from the Retirement System. SHBP will systematically enroll the retiree or the surviving spouse. If the Payroll Location (employer) does not terminate the employee timely, the process will also terminate the employee from active coverage. As the employer, you must verify that the active employment coverage termination date is correct. You should contact the SHBP Employer Services Unit at 800-776-9045 or 404-651-6131 if a correction is needed
   - SHBP will send a letter to the retiree's home address advising of the transfer of coverage. The form, which is on the reverse side of the letter, should be used if the retiree wishes to change options or discontinue health benefit coverage. The retiree should only complete and return the form if he/she is changing options or declining coverage as a retiree. If the retiree is changing options, the form must be received by SHBP within 31 days of the date of the letter. Changes in premiums will be based on payroll processing dates and premiums cannot be refunded
   - SHBP will notify TRS, ERS, and PSERS of the appropriate premium for the coverage. This will also, ensure that the correct premium is deducted from the first annuity check. The file will also include any deduction changes based on retiree change requests and/or Medicare eligibility
   - Then TRS, ERS, and PSERS will return an actual premium deduction file to SHBP following payroll close. This file will be used by SHBP for comparison purposes. It will also list retirees with insufficient annuities. SHBP will set these retirees up to be billed directly for their health benefit coverage

   b) **Pending Retirement:** If the member will not be drawing a monthly annuity from the retirement system immediately following termination through payroll deduction, he/she should telephone the Eligibility Section at 800-610-1863 for additional information

   c) **State Employee who Resigns**: If the member is interested in continuing health benefit coverage on a monthly premium basis, he/she should contact the SHBP within 60 days following coverage termination as an active employee. The member

may call the Eligibility Section at 800-610-1863 for additional information

d) **Teacher or public school employee who resigns or retires**: If a teacher or public school employee who is a member of the SHBP is interested in continuing health benefit coverage on a monthly premium basis, he/she should contact the SHBP within 60 days following coverage termination as an active employee. The member may call the Eligibility Section at 800-610-1863 for additional information

e) **Any person who ceases to be eligible for coverage:** COBRA temporary extended coverage is available to any member or enrolled dependent that loses eligibility for coverage under the SHBP

- **Member:** The member will automatically receive a notice of eligibility for continuation of coverage from the SHBP once the Employing Entity reports the termination of coverage through normal reporting procedures. See Procedure 60-U210

- **Dependent**: The member or enrolled dependent must notify the SHBP within (60) a day following the Qualifying Event in case of divorce, legal separation, or the dependent child loses eligibility

3. Instruct the member to make sure his/her address is correct with the SHBP when a notice from the Plan is expected to be mailed. Instruct the member that should he/she not receive the notice within three weeks after the Forms Transmittal Sheet listing the termination has been submitted, he/she should contact the SHBP by telephone at 800-610-1863.

NOTE: The Form Transmittal Sheet is the Required document to initiate the COBRA notice.

Retirees: Continuation of Health coverage for Retiring Employees

WHO IS ELIGIBLE	
A member may be able to continue Plan coverage if enrolled in the Plan when they retire and are immediately eligible to draw a retirement annuity from any of these systems: • Employee's Retirement System • Teachers Retirement System • Public School Employees Retirement System • Local School System Teachers Retirement System • Fulton County Retirement System (eligible Members) • Legislative Retirement System • Superior Court Judges or District Attorney's Retirement System **Note: Individuals who have withdrawn money from their respective retirement system will not be able to continue health coverage as a retiree. See Procedure 60-U240 for more information. Eligibility for temporary extended coverage under COBRA provision would apply.**	
When Coverage Begins	If an employee is eligible for a monthly annuity at the time of retirement, coverage starts immediately at retirement, provided that the proper premium payments have been deducted from an annuity check. Coverage for dependents (if elect to continue dependent coverage) starts on the same day that the retiree's coverage begins See Procedure for more information A change from single to family coverage as a retiree is allowed only when there is a Qualifying Event.
When Coverage Ends	For Retiree: Coverage will end or discontinue when premiums are not paid on time. For Dependents: Coverage for dependents will end when: • They are no longer eligible • A change from family to single coverage • If premiums are not paid on time • Coverage for the Member ends Note: If dependents are dropped from coverage he/she will not be able to enroll again – unless there is a Qualifying Event.

Continuing Dependent Coverage at Death	In the event of death, the surviving spouse or eligible dependents should contact the applicable retirement system (ERS, TRS, PSERS, etc.) and the SHBP as soon as possible. To continue coverage, surviving spouses or eligible children must complete a Retirement/Surviving Spouse Form and send it to the SHBP Plan within 31 days of the member's death. Plan provisions vary for survivors: **If surviving spouse receives annuity** • Plan coverage may continue after the Retiree's death • Premiums will be deducted from annuity • Spouse sends payments directly to Plan if annuity is not large enough to cover premium • New dependents or spouses *cannot* be added to survivors coverage **If surviving spouse does not receive annuity** • Plan coverage may continue after Retiree's death if the spouse was married at least one year before death • Spouse sends payments directly to the Plan • Coverage ends if surviving spouse remarries Surviving child does not receive annuity and there is no surviving spouse Plan coverage may continue under COBRA provisions
Making Changes to Retiree Coverage	Changes to coverage can be made only at these times: • When there is a Qualifying Event • During the annual Retiree Option Change Period - Changes to Plan Option only Adding dependents is not permitted unless there is a Qualifying Event as described in the Qualifying Events Section

QUALIFYING EVENTS	
Qualifying Events	**<u>Retiree must request a coverage change within 31 days of the Qualifying Event by</u>:** • Contacting the SHBP directly • Returning the necessary form(s) with any requested documentation to the SHBP by the deadline. Fill out the form(s) completely If the deadline is missed, the retiree will not have another chance to make the desired change. If the deadline is met, the change will take effect on the first day of the month following the receipt of the request.

	Changes Permitted Without a Qualifying Event Retirees may change from family to single coverage, or discontinue coverage at any time by submitting the appropriate SHBP form. However, if they change from family to single coverage, they cannot increase their coverage later without a Qualifying Event. Also, if they discontinue coverage, they may not enroll later, unless they return to active employment covered under ERS, TRS or any one of the qualifying retirement systems. **Important Note on Coverage Changes:** If retiree's current Plan option is not offered in the upcoming Plan year and they do not elect a different option available to them during the Retiree Option Change Period, their coverage will be transferred automatically to an option chosen by SHBP effective January 1 of the subsequent Plan Year.

Qualifying Event	
If Retiree's Have This Event	**Action Allowed**
• Within 31 days of eligibility for retiree coverage • Annuity no longer covers premium amount • Become eligible for Medicare	Change to an available option
• Acquire dependent because of marriage, birth, adoption or Qualified Medical Child Support Order (QMCSO) • Within 31 days of loss of a dependent's health benefit coverage through spouse's or former spouse's Medicaid, Medicare, group coverage through active employment, retiree group coverage or COBRA coverage	Add in their eligible dependent(s) Proper documentation is required **Note: Surviving spouse and dependents cannot change from single to family coverage**
• Spouse or enrolled dependent's employment status changes, affecting coverage eligibility under a qualified health plan	Change coverage tier within 31 days of the Qualifying Event; proper documentation is required

• Member and spouse are retirees who both have sufficient retirement benefits from a covered retirement system to have Plan premiums deducted. • New dependents or spouses cannot be added to survivor's coverage	Change at any time from family coverage to each having single coverage, a request to change from family to single for retiree and the request for single coverage for their spouse must be filed at the same time within 31 days of the Qualifying Event.

Medicare Advantage Plan

• Retirees and or their spouses with Medicare coverage must enroll in one of the four SHBP Medicare Advantage options to continue to receive the state contribution to the total cost of your health care

• The SHBP Medicare Advantage Plan will include the 'Standard Plan' and the 'Premium Plan' (with enriched benefits and lower out-of-pocket costs)

• Retirees or their covered dependents who are not eligible for the SHBP Medicare Advantage option because they are not eligible for Medicare Part B will be able to enroll in the HRA, HDHP, Open Access or HMO options from the same vendor

• Retirees and/or their spouses with Medicare coverage, or who are eligible for Medicare Part B but did not enroll, may enroll in the HRA, HDHP, Open Access or HMO options but will pay the entire cost for the coverage.

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What are the 2010 SHBP Plan Options if Retirees Want to Keep the State Contribution?

• CIGNA Standard Medicare Access Plus Rx
• CIGNA Premium Medicare Access Plus Rx

• UnitedHealthcare® MedicareDirectTM Standard Plan
• UnitedHealthcare® MedicareDirectTM Premium Plan

What is a Medicare Advantage with Prescription Drugs (MAPD) Private Fee-for-Service (PFFS) Plan Option?

A Medicare Advantage with Prescription Drugs (MAPD) Private-Fee-for-Service (PFFS), product is an approved plan by the Centers for Medicare & Medicaid Services (CMS) and sometimes called a Medicare Part C Plan. This plan is generally for retirees and their eligible dependents enrolled in Medicare Parts A and B but SHBP has expanded the Medicare Advantage coverage to include those who do not have Part A. This option takes the place of your original Medicare (Part A-Hospital and Part B-Medical Insurance Benefits) and includes a Medicare Part D prescription drug benefit.

The options offer nationwide coverage where members may see any provider willing to accept the Plan's (CIGNA or United Healthcare) terms, conditions and payment rates. This option provides great flexibility in terms of accessibility to medical providers and includes coverage for prescription drugs through the plan's national pharmacy networks.

Currently, SHBP offers two Medicare Advantage Plan Options offered through CIGNA and United Healthcare. The options offered in 2010 and will be called the SHBP MAPD PFFS Standard Plan and MAPD PFFS Premium Plan. Both plans are custom plans with enriched benefits and are structured to reduce/limit retirees' out-of-pocket expenses.

Enrollment in any of the SHBP Medicare Advantage options is subject to CMS approval. CMS requires the correct street address and Medicare number of all enrollees so it is important that SHBP's records are correct when providing information to CMS.

Impact of Medicare on Benefits/Premiums

How Does the SHBP MAPD PFFS Plan Options Work (Medical)?

• Retirees choose any "Deemed" Provider (a provider who is eligible to receive payment from Medicare and who agrees to the CIGNA Medicare Access Plus Rx or United Healthcare Medicare Direct terms, conditions and payment rate)

• Show insurance card

• Pay any applicable co-pay

What is a Deemed Provider and What Does it Have to do with Receiving Care?

• The retiree's doctor must be eligible to receive payment from Medicare and agree to accept the terms and conditions of the plan the retiree is enrolled in. He/she will then be considered a Deemed Provider

• If the doctor or hospital does not agree to be a Deemed Provider, any services received will not be covered (except in cases of emergency)

• If the doctor wants to become a Deemed Provider, the retiree or physician can contact CIGNA or United Healthcare directly

• The provider will file the claims

What About Coverage for Prescription Drugs Under these Plans?

• Most Medicare Part D plans have a deductible and what is called a coverage gap commonly referred to as the "doughnut hole." SHBP has waived the deductible and will provide a benefit through the coverage gap for the retiree. The retiree will only pay your co-pay amount until you reach the plan's predetermined limit of $4550

• Once the retiree reaches the limit the retiree will pay the greater of 5 percent coinsurance or reduced co-pays for generics and brand drugs ($2.50–$6.30) for the remainder of the calendar year

SHBP Medicare Policy

Considerations:

• Must have Medicare Parts A and B **or at least Part B to enroll in a Medicare Advantage Option**

• Prescription drugs are included; the retiree **does not need to purchase a separate Part D Plan**

• If the retiree enrolls in a Medicare Advantage plan through SHBP the Part D coverage will automatically be dropped by CMS

• Must seek services from a "Deemed" provider that accepts CIGNA or United Healthcare's terms, conditions and payment rates

• No filing of claims with Medicare

• Should the retiree drop SHBP Medicare Advantage coverage during the year, original Medicare will automatically go into effect again. The retiree will have a special enrollment period of 63 days from the date coverage was lost to elect a Medicare Part D Plan without penalties applying **BUT SHBP COVERAGE IS PERMANENTLY GONE**

• **If the retiree enrolls in a Medicare Part D Plan after enrolling in a SHBP Medicare Advantage, they will lose your SHBP coverage permanently**

• The retiree cannot be enrolled in a **supplemental** Medicare Advantage plan and have Medicare Advantage coverage under a group plan at the same time

• Once the retiree enrolls in a SHBP sponsored Medicare Advantage Plan, if you enroll in a supplemental Medicare Advantage plan, they will lose their Medicare Advantage coverage under SHBP (this means they will no longer have coverage under SHBP) and will not be able to get coverage back

• The only time the retiree can change your SHBP option is during the ROCP

• Retirees can drop SHBP coverage at any time, but may not re-enroll at a later Date

• The retiree may change to single coverage at any time

What Happens if One of the Prescription Drugs is not Covered Under One of the Medicare Advantage Options?

• If the retiree is taking medication that may require a change (for instance it is not on the approved CIGNA or United Healthcare's drug list) the retiree will receive a letter after the first supply of that medication is received. The letter will tell the retiree what to do and the time period that you have to make a change. After that date, the retiree will be required to change to an alternative medication or complete the necessary steps with their doctor to continue current medication

• The retiree should talk to their doctor and discuss if they should switch to a drug that is covered under the Plan option or request an exception so that the drug the retiree takes will be covered

• The retiree can request an exception by contacting their doctor for a statement supporting their request and submitting to CIGNA or United Healthcare for review and approval

What are the Eligibility Requirements to Participate in this Plan?

• Each individual enrolling in this plan must have Medicare A and B or **at least Medicare Part B.**

• The CMS must verify and approve your eligibility

What if the Retiree Has Medicare Part A but is Not Enrolled in Medicare Part B?

• The retiree is not eligible to enroll in the SHBP MAPD PFFS Options

• The retiree may enroll for Medicare Part B during the Medicare annual enrollment period from January 1–March 31 and will pay the monthly Part B premium to Medicare

• Part B coverage will then become effective on July 1 of the same year and the retiree may request to enroll in one of the Medicare Advantage options at the same time

• The retiree will be responsible for paying any late penalties imposed by Medicare

• After enrolling in Medicare Part B, the retiree will have 31 days to enroll in one of the Medicare Advantage plans. The retiree should contact SHBP on how to enroll in one of the Medicare Advantage Plans

What if Everyone Covered Does not Have Medicare?

- When everyone the retiree covers is not eligible to participate in the MAPD PFFS Options, we call this Split Eligibility. This means that the individual with Medicare enrolls in the MAPD PFFS and any family members that have not yet reached eligibility for Medicare (because of age or not being disabled) can enroll in one of the other options offered by SHBP with the same vendor

This is Confusing – What Are Some Examples?

- Dan is the SHBP retiree with family coverage. Dan has Medicare Part A and B and his spouse, Jean does not. Dan can enroll in one of the MAPD PFFS options and Jean in one of the other SHBP options with the same vendor

- Sam is the SHBP retiree with family coverage. His spouse, Mary, has Medicare Parts A and B and Sam doesn't. Mary can enroll in one of the MAPD PFFS options and Sam can enroll in one of the other SHBP options offered with the same vendor

- Rob and his wife Hazel both have Medicare Parts A and B but have two children in college. Rob and Hazel can choose the same Medicare Advantage Option and the two children can enroll in another SHBP option offered with the same vendor

Can Retiree and Spouse Elect Separate Medicare Advantage Plans?

- Peter is the SHBP retiree with family coverage and goes to the doctor every month and wants to enroll in the MAPD PFFS Premium Plan. His wife, Susan goes once a year for her annual physical and wants to enroll in the MAPD PFFS Standard Plan. Can they each make a separate election? **No; both the retiree and spouse must enroll in the same Medicare Advantage option**

What Does it Mean that the MAPD PFFS Plan Replaces Original Medicare Coverage?

- CIGNA and United Healthcare are licensed by the CMS to offer the SHBP Medicare Advantage Plans

- These plans combine Medicare Parts A, B and D and benefits under SHBP
- One claim is submitted to the health care vendor and one check is sent to the Provider
- Since benefits under Medicare and SHBP are combined, coordination of benefits is not necessary
- The retiree will no longer have to submit claims to Medicare and then to SHBP
- There will be only one explanation of benefits (EOB)
- The retiree only presents their Medicare Advantage ID card when going to the doctor

Helpful Information

Note:
If the retiree enrolls in Medicare please send a copy of Medicare cards by the first of the month in which the retiree is eligible for Medicare. Premiums cannot be reduced until copies of Medicare cards are received and the change in premium is processed by the retirement system. Delay in submission of Medicare information does not qualify for a refund of the difference in premiums.

Medicare information in available at:

- www.cms.gov
- www.medicare.gov
- www.ssa.gov
- 800-669-8387 (Georgia Cares)
- 800-633-4227 (Medicare)

Employer Contribution Rates

The general philosophy for the employer contribution rate is provided by state statute and then further defined by the regulations of the Board of Community Health. Employer rates for the various groups are outlined in the following paragraphs.

- **State:** For all Employing Entities for which employees are eligible for medical coverage under O.C.G.A. 45-18, state statute provides for the employer contribution to be based upon the total personal services. State Personnel Board regulations define personal services to mean total salary payments made to employees. Total salaries include terminal leave pay, overtime pay, shift differential, temporary salaries, and all types of supplemental pay

- **Teachers**: For most Employing Entities (local school systems and RESAs) for which employees are eligible for coverage under O.C.G.A. 20-2-880, state statute provides for the employer contribution to be paid based on total personal services. State Personnel Board regulation defines personal services to mean "state-based" teacher salaries for all persons serving in certificated positions

- **Regional and County Libraries**: The employer contributions are based on a percentage of total salaries, exclusive of per diem and casual labor. Total salaries include terminal leave pay, overtime pay, shift differential, temporary salaries, and all types of supplemental pay. Part-time employee labor who works less than 17.5 hours per week will be considered per diem and casual labor

- **School Service Employees:** For Employing Entities for which employees are eligible for coverage under O.C.G.A.20-2-910, state statute provides for the employer contributions to maintain the same employee contributions amount as other plans administered by the Board of Community Health. By funding policy, the State contributes approximately one-half of the employer contribution and the local school system contributes approximately one-half of the employer contribution for each enrolled employee

All payments for all employer contributions are due on the first of the month coincident with the employees' monthly premium amount. The total premium amount including the employer contribution must be transmitted with the reconciled monthly billing statement by the 5th working day of the month. Failure to remit funds on a timely basis can place health coverage for the specific entity's employees in jeopardy. Documentation requirements for employer contribution calculations are discussed in Procedure 60-U220, Process the Monthly Billing Statement. The monthly employer contribution rate is shown on the following page.

EMPLOYER CONTRIBUTION RATES

Monthly Employer Contribution Rates	
Effective for salaries paid on and after July 1, 2010, the monthly employer contribution rate for the various groups are:	
State	25.586 percent beginning July, 2010
Teachers	21.955 percent beginning July, 2010
Regional and County Libraries	21.955 percent beginning July, 2010
School Service Employees	$162.72

View Direct Reports

Electronic Files and **PROPRIETARY STATEMENT**

The Georgia Technology Authority (GTA) Electronic Reporting System (E-Bill or ViewDirect) is owned by the State of Georgia and operated by the State Health Benefit Plan Division of Information Technology and the Georgia Technology Authority. Unauthorized access is prohibited by the Georgia Computer Systems Protection Act (O.C.G.A. 16-9-90, et seq.), as well as all applicable FEDERAL laws.

The Telecom, DataNet, and Miscellaneous Computer Services Billing information is available on-line via the internet. This process is called Electronic Billing Process (E-Billing) or State Health Benefit Plan (SHBP) ViewDirect; and is accessible according to the information provided by the employing entity.

All information contained in this document is confidential proprietary information of the State of Georgia, the Department of Community Health, and SHBP and must not be shared with unauthorized users.

ViewDirect: TECHNICAL REQUIREMENTS / ACCESS AGREEMENT / USER I.D. AND PASSWORD

Technical Requirements:
Assistance from your IT staff may be necessary in order for you to access this site and utilize all features. **Your IT staff should verify the following:**

- **Pop-up blockers are turned off**
- **Port 8443 is open**
- **Java is installed and enabled on your computer**
- **Security settings are correct to allow downloads from this site**

SHBP ViewDirect Access Agreement:
Authorized employing entities may access various reports electronically for viewing, downloading, and/or printing from the SHBP ViewDirect System by completing a **SHBP ViewDirect Access Agreement. This agreement gives access to the secure site where**

ViewDirect Reports are housed; and grants access to only that specific employing entity as stated in the SHBP ViewDirect Access Agreement.

SHBP ViewDirect Access Agreement(s) are available for printing at the DCH website, www.dch.georgia.gov/shbp or by calling the SHBP Payroll Location/Employer Services Unit at 1-800-776-9045. Complete SHBP ViewDirect Access Agreement(s) should be faxed to the attention of Deborah Sheppard at 1-866-545-3161.

SHBP ViewDirect User I.D.'s and ViewDirect Passwords:

Once the SHBP ViewDirect Access Agreement has been received and verified by SHBP, ViewDirect User I.D.'s and ViewDirect Passwords are assigned according to the agreement. **The SHBP ViewDirect System Administrator is responsible for the following:**

- **the assignment of ViewDirect User I.D.'s (Identifications)**
- **the assignment of ViewDirect Passwords**
- **the resetting of ViewDirect Passwords**

All SHBP ViewDirect System Administrator requests should be made via e-mail to Deborah Sheppard at dsheppard@dch.ga.gov.

Each employing entity may be assigned up to three ViewDirect User I.D.'s and ViewDirect Passwords; and are assigned to specific individuals within the employing entity's location. Each individual must sign an agreement that they will not allow anyone access to their ViewDirect User I.D.'s and ViewDirect Password. The employing entity's location manager will also sign an agreement to immediately advise Deborah Sheppard via email at dsheppard@dch.ga.gov to terminate ViewDirect User I.D.'s and ViewDirect Passwords when assigned users are no longer eligible to access the ViewDirect secure site.

To access an electronic version of the ViewDirect Quick Reference Guide, please visit the DCH website at www.dch.georgia.gov/shbp.

ViewDirect REPORT DESCRIPTIONS

Report Name	Frequency	Content
FBXLQ Flex Open Enrollment Report	As needed	Open Enrollment report available only for Employers participating in the SPA Flexible Benefits Program.
FBXNH Flex New Hire Enrollment Report	As needed	New Hire Enrollment activity report available for employers participating in SPA Flexible Benefits Program.
FLFBXBFP Flex Billing Report	Monthly	Monthly billing for employers participating in SPA Flexible Benefits Program on manual billing.
SHALLMBR Membership Lists – From Billing	Monthly (Also at end of OE)	Monthly report generated in conjunction with the monthly SHBP billing listing all members and their coverage selections for the month. Report is also generated after the close of Open Enrollment. The report generated at this time will list all changes made during open enrollment except for discontinuations. **Download to Excel format using export method (policy): SHALLMBR.**
SHCHG2ST SHBP Possible Tier/Covered Dependent Discrepancies	Daily	Generated daily. Lists employees possibly having inappropriate tier as no dependents are currently covered. Discrepancy may be due to employee's failure to provide approved dependent eligibility documentation in a timely manner. Payroll location should investigate to determine if appropriate to submit form to change tier. **Download to Excel format using export method (policy): SHCHG2ST.**

Report Name	Frequency	Content
SHDATRMS SHBP Dependents Not Verified Report	Daily	Generated Daily. Lists employees having dependents for which dependent verification documentation has been requested, but approved documentation has not yet been received by SHBP. Coverage for these dependents is subject to being rescinded if documentation is not received in a timely manner. **Download to Excel format using export method (policy): SHDATRMS.**

Report Name	Frequency	Content
FBXLQ Flex Open Enrollment Report	As needed	Open Enrollment report available only for Employers participating in the SPA Flexible Benefits Program.
FBXNH Flex New Hire Enrollment Report	As needed	New Hire Enrollment activity report available for employers participating in SPA Flexible Benefits Program.
FLFBXBFD Flex Billing Report	Monthly	Monthly billing for employers participating in SPA Flexible Benefits Program on manual billing.
MEALLMBR Membership Lists – From Billing	Monthly (Also at end of OE)	Monthly report generated in conjunction with the monthly SHBP billing listing all members and their coverage selections for the month. Report is also generated after the close of Open Enrollment. The report generated at this time will list all changes made during open enrollment except for discontinuations. **Download to Excel format using export method (policy): MEALLMBR.**

Report Name	Frequency	Content
MECHG2ST MEMS Possible Tier/Covered Dependent Discrepancies	Daily	Generated daily. Lists employees possibly having inappropriate tier as no dependents are currently covered. Discrepancy may be due to employee's failure to provide approved dependent eligibility documentation in a timely manner. Payroll location should investigate to determine if appropriate to submit form to change tier. **Download to Excel format using export method (policy): MECHG2ST.**
MEDATRMS MEMS Dependents Not Verified Report	Daily	Generated Daily. Lists employees having dependents for which dependent verification documentation has been requested, but approved documentation has not yet been received by SHBP. Coverage for these dependents is subject to being rescinded if documentation is not received in a timely manner. **Download to Excel format using export method (policy): MEDATRMS.**
MEDEVUTC MEMS DEV Termination Report	Daily	Generated daily. Lists employees having dependents for which the dependent's coverage has been rescinded due to failure to provide the proper dependent verification documentation within the time specified. **Download to Excel format using export method (policy): MEDEVUTC.**
MEFMLABLMEMS FMLA Bills- Detail	Monthly	Generated monthly at the time Direct Pay bills are generated. Report list employees on Family Medical Leave for which the $5.00 administrative fee is payable by the payroll location.
MELWOPMB MEMS Members in LWOP Locations	Daily	Generated daily. This is a list of employees SHBP shows on LWOP. Report includes: Option/Type of coverage, LWOP type, Projected Begin Date and Projected End Date. **Download to Excel format using export method (policy): MELWOPMB.**

Report Name	Frequency	Content
MEMSBILL MEMS Location Bills	Monthly	Generated Monthly. SHBP Billing. **Download report 360-H141 (Current & retroactive Transaction list) to Excel format using export method (policy) MEMSBILL.** *This export method (policy) includes premium changes.* **Download report 360-H141 (Current & retroactive Transaction List) to Excel format using export method (policy): MEMSBIL2.** *This export method (policy) does not include premium changes.* **Download report 360-H142 (Reported Membership Totals) to Excel format using export method (policy): MEMSBIL3.**
MEPRFBLL MEMS Location Proof Bills	Daily	Generated Daily. SHBP Proof Bill. **Download report 360-H141 (Current & retroactive Transaction list) to Excel format using export method (policy) MEPRFBLL.** *This export method (policy) includes premium changes.* **Download report 360-H141 (Current & retroactive Transaction List) to Excel format using export method (policy): MEPRFBL2.** *This export method (policy) does not include premium changes.* **Download report 360-H142 (Reported Membership Totals) to Excel format using export method (policy): MEPRFBL3.**
MESHBPIN MEMS SHBP Cov Employees and Disc Interface	Monthly	Monthly report generated in conjunction with the monthly SHBP billing. Provides same coverage information as MEALLMBR but includes discontinuations and premium information. This report is also generated after the close of Open Enrollment. The report will show all changes made during Open Enrollment including discontinuations. **Download to Excel format using export method (policy): MESHBPXL.** **Download to Text Format using export method (policy): MESHBPIN.**

Report Name	Frequency	Content
MEXXXXXR MEMS Payroll Deduction Compare Detail	Monthly	Generated Monthly upon receipt of payroll deduction information. “XXXXX” represents each location’s SHBP payroll location number. This is a detail report showing all discrepancies found when comparing information in the Payroll deduction file with enrollment information contained in MEMS.
MEXXXXXS MEMS Payroll Deduction Compare Interface File	Monthly	Generated Monthly upon receipt of payroll deduction information. “XXXXX” represents each location’s SHBP payroll location number. This is a summary file which can be downloaded into Excel format. See below instructions on downloading this report.
MEWBNCFM MEMS Open Enrollment Unconfirmed Covered Employees	Daily	Generated Daily during Open Enrollment period. Lists currently enrolled SHBP members who have not accessed the Open Enrollment Web site to make Open Enrollment elections and respond to surcharge questions. Final report generated each year at the end of the Open Enrollment period. **Download to Excel format using export method (policy): MEWBNCFM.**

Report Name	Frequency	Content
ME523961 MEMS Web Availability Cross Reference Report	Annually	Generated annually prior to the beginning of the Open Enrollment period. Provides a listing of all employees who currently have SHBP coverage and those provided by the employers as being eligible to enroll for SHBP coverage during Open Enrollment. Contains employee's name, SSN and DOB. Report can be accessed to check above info if employee is experiencing problems logging in on Open Enrollment Web site. **Download to Excel format using export method (policy): ME523961.**

SHXXXXXR SHBP Payroll Deduction Compare Detail	Monthly	Generated Monthly upon receipt of payroll deduction information. "XXXXX" represents each location's SHBP payroll location number. This is a detail report showing all discrepancies found when comparing information in the Payroll deduction file with enrollment information contained in the SHBP eligibility system.
SHXXXXXS SHBP Payroll Deduction Compare Interface File	Monthly	Generated Monthly upon receipt of payroll deduction information. "XXXXX" represents each location's SHBP payroll location number. This is a summary file which can be downloaded into Excel format. See below instructions on downloading this report.
SHWBNCFM SHBP Open Enrollment Unconfirmed Covered Employees	Daily	Generated Daily during Open Enrollment period. Lists currently enrolled SHBP members who have not accessed the Open Enrollment Web site to make Open Enrollment elections and respond to surcharge questions. Final report generated each year at the end of the Open Enrollment period. **Download to Excel format using export method (policy): SHWBNCFM.**

SH523961 SHBP Web Availability Cross Reference Report	Annually	Generated annually prior to the beginning of the Open Enrollment period. Provides a listing of all employees who currently have SHBP coverage and those provided by the employers as being eligible to enroll for SHBP coverage during Open Enrollment. Contains employee's name, SSN and DOB. Report can be accessed to check above info if employee is experiencing problems logging in on Open Enrollment Web site. **Download to Excel format using export method (policy): SH523961.**

- Go to View Direct
- Select MEXXXXXS
- Select/open the report for the month you want to work with
- Click on the "download" icon on the toolbar at top of the page
- Download window "pop up" box will appear
- It will default to the radio button for "current page" selected. Change to "all"
- Leave everything else in this window as it is
- Click on "create" button. (Top button of three buttons to the right in this window)
- When next window appears, choose "save"
- (When next window appears- watch where you are saving document)
- Change file name to: XXXXX.zip
- Leave "type" as winzipfile
- Save
- Choose "Open"
- Choose "I agree"
- Open "archive.txt" file. Should have "readable" test file
- Go to "File"
- "Save as"
- (Again watch where you are saving this file)
- Change name to "XXXXX.txt"
- Leave everything else as is
- Save

Next Steps:

- Open Excel
- Go to "file"
- Open
- Locate your document – will probably need to change file type to "all files"
- Select your compare file
- Text import window will appear
- Change "original data type" to "delimited"
- Select "next"

- Change “delimiters” from “tab” to “semicolon”
- Select “next”
- Change “column data format” to text
- Under “Data Preview” select all columns. (First column will be highlighted. Hold shift key and go to last column. Click on this column should select all of them.)
- Select “finish”
- Should now be in Excel format for you to adjust column widths and save

GLOSSARY

1) **Accredited School** for the purpose of determining eligibility under DCH Regulations, SHBP means any one of the following types of schools:

- Any secondary educational or secondary institution with postsecondary programs accredited or pre-accredited by accrediting associations that are recognized by the United Stated Secretary of Education or
- Any professional, technical, occupational and specialized school accredited or pre-accredited by national specialized accredited agencies recognized by the United States Department of Education; or
- Any specialty or other school administered by the Department of Education or Post Secondary Vocational Board of the State of Georgia; or
- Any school that has applied for or is a "candidate for" accreditation under the Rules of the DCH, SHBP, Sections 111-4-1-.01 (1)(a) or 111-4-1-.01 (1)(b); or
- Any institution of higher education as defined by the Higher Education Act of 1965 (20 USCS 1141)

2) **Annuitant** means a Retired Employee or surviving spouse or dependent child, who receives a monthly retirement benefit from the Employee Retirement System, Georgia Legislative Retirement System, Superior Court Judges Retirement System, District Attorney's Retirement System, Teachers Retirement System, Public School Employees Retirement System, local school system retirement system or Fulton County Retirement System.

3) **Approved Leave of Absence Without Pay (LWOP)** 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.

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

5) **Certified 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 certification; and the employee is a member of the Teachers Retirement System or other public school teacher's retirement system.

6) **Contract Employee** means a person employed by one of the employing entities that contract with the Board of Community Health to provide health benefit coverage under the SHBP and who is not considered to be an independent contractor.

7) **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

8) **Covered Dependent** means any individual eligible under these regulations and for whom the premium has been paid by the employee, retiree, or extended beneficiary

9) **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 (HMO's); Medicaid; Medicare; or other government 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

10) **Deductible** is a set dollar amount for covered services that the member must pay out-of-pocket each Plan Year before the OAP Option, Indemnity Option, or HRA pays certain benefits

11) **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

12) **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 legally dependent upon the subscriber for financial support

13) **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 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 institutions full-time requirements during periods of full-time student or period of disability

14) **Employee** means any active, eligible employee of State Agencies, Health Departments, RESAs, Libraries, CSBs, DFACS, Technical Colleges and Public Schools as well as certain Contract Groups

15) **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 a check to an Employee or Retiree as defined in the regulations

16) **Fulltime Student** means the natural children, legally adopted children, stepchildren or other children, age 19 to 26, who are registered as a full-time student for the minimum number of hours required to meet full-time student status at an accredited institution. Full-time students whose verification documentation is not submitted timely will not be eligible for coverage until the following Open Enrollment or a qualifying event occurs. Verification documentation must be submitted before age 19 and each subsequent year to keep the student's eligibility active

17) **Monthly Billing Statement(s)** are monthly reports transmitted to the employing entity from SHBP utilized to verify and/or correct eligibility records for the month. On or around the 25th of each month, each reporting entity may access their monthly billing reports electronically for viewing and/or printing on the SHBP View Direct System

18) **Non-certified employees** hold non-certified positions and are 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

19) **Option** means the type of benefit schedule or premium rating category that is offered to the subscriber through regular insurance or a HMO

20) **Plan or State Health Benefit Plan (SHBP)** means the insurance Options formed by the combination of health insurance plans for state employees, teachers, public school employees, contract employees and retirees

21) **Plan Options** are the health insurance options offered to state employees, teachers, public school employees and contract employees (i.e. PPO, HDHP, HMO, HRA, etc.)

22) **Pre-existing condition (PEC)** means a sickness, injury, or other condition (except 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 PEC unless diagnosis, care or treatment was rendered within the six-month period; part of the Health Insurance Portability and Accountability Act of 1996

23) **Premium** means the subscriber's cost as set by the Board of Community Health for the coverage tier and option

24) **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 health benefit plan. Qualifying Events include changes in employment or family status

25) **Spouse** means an individual who is not legally separated, who is of the opposite sex of the subscriber and who is legally married

26) **Spousal Surcharge** will be added to the employee's monthly premium if they elect to cover a spouse who is eligible for coverage through his/her employment but chose not to take it. If the spouse is not eligible for coverage through his/her employer, the spousal surcharge will be waived. The spousal surcharge will automatically be charged if all questions concerning the spousal surcharge are not answered

27) **State Health Benefit Plan (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

28) **Surviving Spouse** means the living spouse of a deceased employee or retiree

29) **Tobacco Surcharge** will be added to the monthly premium if the employee or covered dependents have used tobacco products in the previous 12 months. The tobacco surcharge may be removed by completing the tobacco cessation requirements

30) **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 unable to perform the normal activities of a person of like age or sex

31) **Tier** means family or single coverage for eligible dependents. Effective January 1, 2009 the tiers will be, 1) employee only, 2) employee+spouse, 3) employee+child (ren), 4) employee+spouse+child (ren)

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