

## SYNOPSIS

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

#### STATEMENT OF PURPOSE AND MAIN FEATURES OF PROPOSED RULE

The purpose of this proposed amendment is reflect the Department's existing operational systems which enable the enrollment of members into the state health plan by employers. The amendment deletes any reference to electronic eligibility enrollment.

#### DIFFERENCES BETWEEN EXISTING AND PROPOSED RULES

The existing regulation 111-4-1-02(3)(a) has been deleted in it's entirely.

The existing regulation 111-4-1-.02(3)(b) is realigned in accordance with the above-reference deletion, and modified to remove any reference to *electronic* enrollment, along with subsections (3)(e), (3)(f), (3)(g) and (3)(h).

**RULES  
OF  
DEPARTMENT OF COMMUNITY HEALTH**

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

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

**(1) Functions, Duties and Responsibilities of the Board of Community Health.**

The Board shall provide policy direction for the operation of the State Health Benefit Plan. Other responsibilities as defined by law are:

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

1. Provide reasonable hospital, surgical, and medical benefits with cost sharing of expenses for each such type to be incurred by the Enrolled Members, Dependents and the Plan;

2. Include reasonable controls, which may include deductible and reinsurance provisions applicable to some or all of the benefits, to reduce unnecessary utilization of the various hospital, surgical and medical services to be provided and to provide reasonable assurance of financial stability in future years of the Plan; and

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

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

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

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

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

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

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

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

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

The Commissioner is authorized to establish necessary procedures to implement the receipt of the Employer Contribution on a timely and accurate basis.

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

(e) **Approve Contracts.** The Board is authorized to approve contracts for insurance, reinsurance, health services and administrative services for the operation of the Plan. The Board shall also approve contracts to include HMOs and Consumer Driven Health Plans ("CDHP") as an alternative to Regular Insurance and approve contracts as authorized by law with governments, authorities, or other organizations for inclusion in the Plan.

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

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

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

Retirement Fund of Georgia, the Georgia Housing Authority, and the Georgia Agrirama Development Authority, the Retiree's cost of Coverage shall be deducted from the Retired Enrolled Member's annuity payment. In addition, each Contract Employer shall make the Employer Contribution required for inclusion in the Plan and remit such payments in accordance with procedures as the Administrator may require.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(g) **Develop and Publish Plan Document.** The Commissioner shall cause to be developed a Summary Plan Description (SPD) or Certificate of Coverage which incorporates the approved schedule of Benefits, eligibility requirements, Termination of Coverage provisions, Extended Coverage provisions, to whom benefits will be payable, to whom claims should be

submitted, and other administrative requirements. The Commissioner or designee shall cause a pre-determined percentage of the SPD's to be printed and distributed to each local and state Employer for distribution to Enrolled Members. The Commissioner or designee shall cause to distribute the SPD to Retired Enrolled Members and Extended Beneficiaries at their last known address.

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

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

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

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

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

~~(a) **Electronic Enrollment Process.** Each Employing Entity and retirement system is responsible for the timely creation of electronic enrollment system records necessary for the proper administration of their Employee's and Annuitant's eligibility and participation in the SHBP. Failure to add, update or correct employment records may result in the Employee's or Annuitant's loss of eligibility to participate in health Coverage. Failure to provide the~~

~~Administrator timely confirmation of Member payroll Deductions/Reductions shall result in suspension of Member benefit payments.~~

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

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

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

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

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

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

~~(f)(g)~~ **Administer Leave Without Pay Provisions.** Each Employing Entity shall administer Approved Leave of Absence Without Pay and Family and Medical Leave Act Programs in compliance with the federal laws and shall provide information regarding the

conditions for continuing Coverage under the SHBP to eligible Enrolled Members. ~~Each Employing Entity shall maintain an Enrolled Member's eligibility within the electronic enrollment system to continue SHBP Coverage under the provisions of these regulations during a period of Approved Leave of Absence Without Pay.~~ Each Employing Entity shall also provide continuation of Coverage ~~electronic~~ enrollment information to Members. Each Employing Entity shall insure Members on Approved Leave of Absence Without Pay are properly notified of the annual Open Enrollment period and afforded the opportunity to enroll or change Coverage.

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

Authority: O.C.G.A. §§ 45-18-1 *et. seq.*, 20-2-881, 20-2-883, 20-2-884, 20-2-885, 20-2-891, 20-2-892, 20-2-893, 20-2-894, 20-2-895, 20-2-896, 20-2-911, 20-2-912, 20-2-913, 20-2-914, 20-2-915, 20-2-916, 20-2-918, 20-2-919, 20-2-920, 20-2-921, 20-2-922, 20-2-924, 31-5A and 20-2-55, Health Insurance Portability and Accountability Act (HIPAA), Consolidated Omnibus Budget Reconciliation Act (COBRA), Family Medical Leave Act FMLA).

## SYNOPSIS

### *Rule 111-4-1-.04* *Eligibility for Coverage*

#### STATEMENT OF PURPOSE AND MAIN FEATURES OF PROPOSED RULE

The purpose of this proposed amendment is to provide notice to employees on leave that failure to pay timely premiums will terminate coverage. The amendment also informs the employee how and when coverage is reinstated.

#### DIFFERENCES BETWEEN EXISTING AND PROPOSED RULES

The existing regulation 111-4-1-.04(6)(j) has been modified to terminate versus suspend coverage, reflecting the operational capacity of the existing system.

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

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

(a) **Full-Time.**

1. State Employees who work a minimum of thirty (30) hours per weeks are considered full-time.
2. A regular full-time Employee who receives a salary or wage payment from a state department, board, agency, commission, the general assembly, a community service board, or a local government or other organization with which the Board of Community Health is authorized to contract; except contingent workers of the Labor Department, specially classified Employees of the Jekyll Island State Park Authority, Employees working as an independent contractor or on a temporary, seasonal, or intermittent basis and Employees whose duties are expected to require less than nine (9) months of service.
3. A regular full-time Employee who receives a salary or wage payment from a state authority that participates in the Employees' Retirement System;
4. Part-time Employees of the General Assembly who had coverage prior to January 1981, and Administrative and clerical personnel of the General Assembly;
5. A full-time district attorney, assistant district attorney who was appointed pursuant to O.C.G.A. § 15-18-14, or district attorneys' investigators appointed pursuant to O.C.G.A. § 15-18-14.1 of the superior courts of this state;
6. A full-time Employee who receives a salary or wage payment from a county board of health or a county board of family and children services that receives financial assistance from the Department of Human Resources; except for sheltered workshop Employees;
7. Full-time secretaries and law clerks who are employed by district attorneys and judges and are employed under O.C.G.A. §§ 15-6-25 through 15-6-28 and O.C.G.A. §§15-18-17 through 15-18-19.

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

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

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

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

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

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

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

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

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

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

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

(4) **Eligibility for Coverage as an Enrolled Member Limited.** In the situation where the Enrolled Member is entitled to Coverage under the SHBP as an Active Employee under a health insurance act and Retired Employee under a different health insurance act, or any combination of provisions, the Member may choose among the Active Employee provisions under which the Member will be covered, but may not choose Coverage as a Retiree or Beneficiary of a Retiree as long as the Member is eligible for Coverage under one of the Active

Employee provisions. In no circumstance shall the individual be an Enrolled Member under more than one provision of these regulations.

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

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

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

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

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

(b) **Reduced Working Hours Due to Partial Disability.** A Partial Disability leave is the period of time during which an Employer approves an Employee's return to work on a part-time basis from a period of disability leave or paid leave if the part-time work is part of a process to gradually return the Employee to full-time work. Coverage may be continued under this

provision for the period of disability approved by a licensed physician, but not longer than twelve (12) consecutive calendar months, inclusive of any time from a period of disability leave without pay. Certification of the Partial Disability period shall be required to continue coverage under this provision.

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

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

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

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

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

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

(i) **Sequential Periods of Leave.** Health benefits may be continued during sequential types of leave, provided that continuation of health benefits during continuous, sequential periods of time shall not exceed the time limitation of the most recently approved type of leave.

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

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

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

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

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

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

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

meet the test of legal dependency and that other legal papers present undue hardship on the Member or living natural parent(s).

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

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

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

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

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

(a) **Application Period.** The Enrolled Member must apply for continuation of Coverage and include all supporting documentation prior to the end of the month in which the child reaches age nineteen (19) or loss of continuous Coverage as a full-time student under this Plan. If the Enrolled Member fails to complete the request within the allotted time, eligibility for Coverage is limited to the conditions outlined for full-time students or Extended Beneficiaries. If, however, the Dependent child was eligible for Coverage under the SHBP as a disabled Dependent upon reaching age nineteen (19), an Enrolled Member shall be entitled to apply to enroll the disabled Dependent upon loss of other group plan Coverage, provided the Administrator receives the complete application no later than thirty-one (31) calendar days following the loss of another group health plan Coverage or prior to the loss of continuous Coverage as a full-time student under this Plan.

(b) **Documentation and Approval.** The Administrator shall require documentation as necessary to provide certification that the child is physically or mentally incapable of sustaining, self-supporting employment because of the physical or mental disability and that the child lives at the Enrolled Member's home, unless institutionalized. The documentation may include but is not limited to certification from a qualified medical practitioner that outlines the physical and psychological history, diagnosis, and provides an estimate of length of time for disability, and an estimate of the child's earning capacity. If the documentation is satisfactory to

substantiate the physical or mental disability as required in these regulations, the Administrator may approve the continuation for the period of incapacitation. The Administrator may require periodic recertification of the disabling condition and circumstances, provided the recertification is not more frequent than each twelve (12) calendar months or at the end of the projected disability period if that date is less than twelve (12) calendar months.

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

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

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

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

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

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

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

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

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

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

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

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

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

## SYNOPSIS

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

### STATEMENT OF PURPOSE AND MAIN FEATURES OF PROPOSED RULE

The purpose of this proposed amendment is to provide notice to employers and members that failure to pay timely premiums will terminate coverage. The amendment also informs the employers and members how and when coverage is reinstated.

### DIFFERENCES BETWEEN EXISTING AND PROPOSED RULES

The existing regulation 111-4-4-.05(6) has been modified to terminate versus suspend coverage, reflecting the operational capacity of the existing system.

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

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

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

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

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

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

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

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

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

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

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

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

(6) **Premium.** The Administrator shall ~~suspend terminate~~ Coverage of Enrolled Members and Covered Dependents for which the Plan has not received full payment of the

required Premium prior to the first day of the Coverage month. ~~Terminated Suspended~~ Coverage will be reactivated upon receipt of full payment of the required monthly Premium.

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

## SYNOPSIS

### *Rule 111-4-1-.06 Changes in Coverage and Option*

#### STATEMENT OF PURPOSE AND MAIN FEATURES OF PROPOSED RULE

The purpose of this proposed amendment is to modify the events that may allow a member to enroll in the state health plan outside of open enrollment due to loss of coverage.

#### DIFFERENCES BETWEEN EXISTING AND PROPOSED RULES

The existing regulation 111-4-1-.06(6)(c) has been modified to delete possible elective *discontinuance* by a member from another group health plan to enroll in the state health plan. Loss of coverage is sufficiently qualified under the regulation to address legitimate member inability to continue enrollment in another group health plan during the plan year.

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

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

(a) **Active Employees.** Eligible Active Employees, eligible Employees on Approved Leave of Absence Without Pay and Extended Beneficiaries shall be given an opportunity to enroll or change Coverage during the Open Enrollment period.

(b) **Retirees.** During the Retiree Option Change Period, enrolled Retirees shall be given an opportunity to change Coverage Option to any Option for which the Retiree is eligible.

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

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

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

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

(6) **Qualifying Life Event Coverage Changes.** A Member shall be eligible to change Coverage election as outlined in these regulations. Requests to enroll, change, or discontinue coverage must be received by the Administrator no later than thirty-one (31) calendar days following the qualifying event. The effective date of the Coverage election shall be the first of the month following receipt of the request, unless otherwise noted in these provisions. The Administrator shall request supporting documentation to demonstrate the Qualifying Event has occurred. Failure to fully document the occurrence of the Qualifying Event

within the allotted time shall result in reversal of the Coverage election and restoration of the Member's prior Coverage election.

(a) **Marriage Resulting in Dual Coverage.** When an Enrolled Member marries and becomes eligible through the new spouse's employment, the Enrolled Member may discontinue coverage or decrease Coverage Tier, provided that all enrolled persons under the Enrolled Member's contract are covered under a group health benefit plan. Documentation of enrollment under the other employer's group health benefit plan shall be required by the Administrator.

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

(c) **Loss of Other Coverage.** An Enrolled Member may change Coverage under the SHBP when he or she loses membership under some other group health benefit plan as a result of divorce, legal separation, or death. When an Enrolled Member or an Enrolled Member's Spouse loses Coverage through employment, the Enrolled Member may increase Tier. When an Active Employee, an Employee's Spouse, or any eligible Dependent loses ~~or discontinues~~ enrollment under a group health benefit plan through other employment, or under Medicaid or Medicare, the Employees may enroll themselves and any eligible Dependents in SHBP Coverage. Loss of membership under another group health benefit plan through employment can be the Member's, Spouse's or former Spouse's change in employment status affecting eligibility for group health benefit plan membership under a Cafeteria Plan or other qualified health benefit plan, the former Spouse's refusal to continue covering health benefits for the Dependent children, an Approved Leave of Absence Without Pay by the Spouse or former Spouse resulting in termination of group health benefit plan membership or no Employer's Contribution to the Premium, or the termination of the Member's, Spouse's, or former Spouse's group health plan through his or her employment, or the termination of COBRA. Documentation of the loss of membership under another group health benefit plan, or under Medicaid or Medicare, shall be required by the Administrator.

(d) **Loss of Dependents.** When an Enrolled Member loses all Dependents through one of the following: (1). divorce (2). death (3). legal separation; or (4). the loss of eligibility of an only Covered Dependent who no longer meets the definition of an eligible Dependent, the Administrator shall decrease the Member's Tier. An Enrolled Member may request a decrease in Tier when a Qualified Medical Child Support Order ("QMCSO") judgment, decree or order resulting from a divorce, legal separation, annulment, or change in legal custody requires a former Spouse to provide health Coverage for the Member's Covered Dependents; documentation of the order and Dependent Coverage under another health plan shall be required. No refund of Premiums will be allowed for this decrease in Tier.

(e) **Birth of Dependent.** A Member, except as provided in Section 111-4-1-.08 of these regulations, may enroll themselves and all their eligible Dependents in Coverage or increase Tier. The effective date of the Coverage change shall be the first of the month following the request unless the Member specifically elects to include the newborn in Coverage from the date of birth. When the Member elects to include the newborn from the date of birth the effective date of the Coverage change shall be the first of the month of birth. The Administrator shall require that payment of the appropriate Premiums for prior months of Coverage be collected from the date the Member elects for the Coverage to become effective. This provision

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

(f) **Change in Employment Status.** An Active Employee may decrease Tier or discontinue Coverage when the Spouse's or only Covered Dependent's employment status changes and affects the individual's eligibility under a Cafeteria Plan or other qualified health benefit plan and all covered persons removed from the contract are covered under the other employer's group health benefit plan. The Administrator shall require documentation of the other group health benefit plan enrollment. The effective date of the change in Coverage or discontinuation shall be the latter of the first of the month following receipt of the request or the date that the Employee and Covered Dependents are covered under the other group health benefit plan.

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

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

(i) **Retired Employees.** Married enrolled Retirees may change Tier in order to become individual Enrolled Members at any time when no individuals other than the Spouse are enrolled in the Coverage. The change in Coverage will be effective within two (2) calendar months following the requested change.

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

(k) **Change to Family at Time of Involuntary Separation.** When an Enrolled Member is involuntarily separated, an increase in Tier is allowed at the time of retirement, provided the Member will immediately begin drawing a monthly benefit from a participating

retirement system. The Administrator shall require documentation to substantiate the involuntary separation.

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

(m) **Managed Care Plan Options.** An Enrolled Member may change to, among, or from a Managed Care Plan when:

1. The Enrolled Member changes residency to a location that is no longer considered a part of the Managed Care Plan's network of providers contracted with the SHBP;

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

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

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

1. At the time of retirement;

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

3. At the time that the Retired Member becomes eligible for Medicare coverage.

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

Authority O.C.G.A. §§ 20-2-295, 20-2-881, 20-2-894, 20-2-897, 20-2-911, 20-2-922, 45-18-1 et seq., 50-18-72, 50-18-94, Internal Revenue Code Section 125 – Family and Medical Leave Act of 1993 (FMLA), Consolidated Omnibus Budget Reconciliation Act (COBRA), IRS Code Section

125, Health Insurance Portability and Accountability Act (HIPAA), Child Support Performance and Incentive Act, U.S.E.R.R.A.