



# *Health Plan Select Group Administrator Manual*

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# I. INTRODUCTION

## *Welcome to Health Plan Select!*

This manual has been prepared especially for you, the Group Administrator. Its purpose is to make your job as easy as possible, and to provide the information you need to successfully administer your Health Plan Select (HPS) Health Care Plan. We look forward to working with you to give your covered employees and their eligible dependents the service they deserve.

This Group Administrator Manual is provided to help with enrollment and answer commonly asked questions about the Plan. For questions regarding Plan Coverage, please refer to the Evidence of Coverage attached to this document. In the case of conflicting language between this document and the Evidence of Coverage, the language in the Evidence of Coverage will control.

Please take some time to review this manual, so that you will know where to find answers when you need them. Please do not hesitate to call us if you have any questions.

## *About HPS*

Health Plan Select (HPS) is a not-for-profit provider sponsored health plan serving the residents of Northeast Georgia. HPS offers a full range of primary care, preventive care, inpatient, and specialty care services through participating hospitals and physicians. HPS also has providers for home healthcare, durable medical equipment, pharmacy and other ancillary services.

## *The HPS Service Area*

Health Plan Select is currently licensed to serve 18 counties in Northeast Georgia:

Banks	Gwinnett	Oconee
Barrow	Habersham	Oglethorpe
Clarke	Hart	Stephens
Elbert	Jackson	Taliaferro
Franklin	Madison	Walton
Greene	Morgan	Wilkes

## *How to Use This Manual*

Use this manual to become familiar with the policies and procedures you will need to administer your HPS Plan. Also use it as a resource when specific questions rise. We have included a complete set of forms and other materials mentioned throughout the manual in the last section. We will provide the most up-to-date version of the manual and forms on our web site so for future changes please visit our site at [www.aahps.com](http://www.aahps.com).

## *Roles and Responsibilities*

The Group Administrator and the staff at HPS share the responsibility for introducing employees to the Plan so that they can make an informed decision about their health care benefits. Here is a summary of responsibilities:

<b>Group Administrator</b>	<b>Member Services</b>	<b>Sales</b>
Present HPS Information to employees.	Answer questions from members, and assist Group Administrators in providing information	Assist Group Administrator during sales and implementation process
Answer employee questions about how to communicate with HPS	Maintain computer systems that accurately reflect member information	Respond to requests from Group for information at renewal time (new plans, riders, etc.)
Notify Member Services of new members and any changes to existing members.	Maintain accurate information about the Group's membership.	Notify other HPS staff of changes to the original group contract.
Receive and review premium bills and initiate payment.	Produce and distribute Member ID Cards.	

HPS is responsible for creating and maintaining systems that will allow members access to their benefits, that will generate Membership ID cards, and that will generate monthly bills.

The Group Administrator and group employees are responsible for timely notification of changes to HPS, and timely payment of premiums. HPS is responsible for the timely update of systems, production and distribution of bills, processing of premium payment, and paying claims.

## *Who To Call With Questions*

Our office is open Monday through Friday, 8:30 a.m. to 5:00 p.m., and is located in downtown Athens. Here is how to reach us:

***By mail***                      Health Plan Select, Inc.  
295 W. Clayton Street  
Athens, GA 30601

***By phone***                      Member Services -8:30 am - 5:00 pm (Mon. - Fri.)  
(706) 549-0549, extension 2  
(800) 293-6260, extension 2

***You may call 24 hours a day – if Member Services is not available - you may leave a message.***

*By fax*                      Member Services (706) 549-8004  
    Sales Dept. Fax (706) 425-1824

***When Calling Us***

<b>For:</b>	<b>Call (706) 549-0549</b>
Benefit Information Claim Questions Eligibility Verification Adding or Deleting Dependents ID Cards PCP Inquiries & Changes Complaints / Grievances	and press 2 for <b>Member Services</b>
<b>For:</b>	<b>Call: (706) 549-0549</b>
Enrollment Forms Change Forms New Hire Packets Provider Directories Other Collateral Materials Transition of Care Forms	and press 1 for <b>Sales Department</b>

If you need supplies for your group, you may call our office, or you may fax us the Request For Supplies Form indicating which supplies you need. (A copy of the Request For Supplies Form is included in Section IX - Forms and Materials).

If you need to reach a specific department:

Dial the Health Plan Select phone number: 706/549-0549 or 800/293-6260

- Then Press:    **#2 Member Services**  
                          **#3 Quality & Utilization Management**  
                          **#1 Sales**  
                          **#5 Provider Relations**

Dial Ext. 6303 - Enrollment Coordinator

Dial Ext. 6313 - Account Manager

Dial Ext. 6335 - Account Manager

Dial Ext. 6307 - Finance

## II. Enrollment Requirements

### *Employee Eligibility Requirements*

Employees who meet the following requirements are eligible to enroll for Health Plan Select coverage:

***Meet Employer's Eligibility Requirements:*** Employees must be an active employee, (including owners, proprietors, and partners), who work a minimum of thirty (30) hours on average per week for your company and for whom you deduct FICA taxes for any earnings.

***Live or Work in the Service Area:*** Employees must live *or* work in the Health Plan Select Service Area.

***Complete Enrollment Form:*** Eligible employees must complete the required Health Plan Select enrollment application within 31 days of the date the employee became eligible.

***Medicare:*** If your employee has Medicare coverage, please contact The Membership and Benefits Coordinator at HPS for coordination of benefits clarification. A copy of the employee's Medicare coverage card is required with the enrollment form.

### *Dependent Eligibility*

Employee's dependents that meet the following requirements are eligible to enroll for Health Plan Select coverage:

***Spouse:*** The legal spouse of an enrolled employee is eligible for dependent coverage with HPS.

***Dependent Children:*** Unmarried natural and adopted dependent children under 19 years of age are eligible to enroll.

***Step Children:*** Stepchildren of the eligible employee who live with the employee are eligible to enroll. Employees who are court ordered to cover their children who live out of the service area may do so if they enroll in a Point of Service Plan. HMO plans would only provide coverage for emergency services. If an employee's spouse is court ordered to cover his/her children, the children must live with them to be eligible for coverage.

***Students:*** A dependent child who meets the following requirements may be granted student status and therefore be eligible to enroll:

1. Is between the ages nineteen (19) and twenty-six (26)
2. Is attending an accredited post-secondary educational institution\*\* on a full-time (minimum 12 hours) basis. Full-time basis means a non-correspondence course; which includes school attendance for five calendar months or more.
3. Is primarily dependent on the subscriber or the subscribers spouse for support, and

4. Is eligible to be claimed as a dependent on the subscriber's or the subscriber's spouse's income tax return.

\*\*A post secondary educational institution is defined as an institution of higher learning having an organized curriculum and requiring class attendance for a minimum number of hours per quarter or semester, and which is accredited by a government agency or nationally or regionally recognized accreditation association, or which is approved for educational benefits by either the Georgia Department of Education, the United States Veteran's Administration, or other state or federal agency. This term includes, but is not limited to, colleges, universities, vocational or technical schools, professional or graduate schools. This term does not include cosmetology school, barber school, equestrian school, sports school, bartender school, cooking school or other similar training.

***Any employee enrolling a student must provide an original letter from the registrar's office of an accredited school stating their son/daughter is a full-time student. (A student's schedule or receipt for payment is not acceptable verification of student-status). Student Status Verification forms are available from the Member Services Department (a copy is provided in the forms section of this manual).***

HPS verifies student status twice annually, once in January and again in August. It is the responsibility of the employee to ensure this information is requested from the school and forwarded to HPS. Claims will be denied until this information is received. In addition, it is the responsibility of the employee to notify HPS if their child is no longer a full-time student. Applicable premium reductions will be made effective immediately upon receipt of the notification. Retroactive premium adjustments will not exceed two (2) calendar months.

Students covered under an HMO plan who are attending school outside the service area are only eligible to receive Emergency Care while outside the service area. If your group has selected a Point of Service Plan, benefits for covered services outside the service area will be covered subject to applicable deductibles and coinsurance.

***Handicapped or Disabled:*** Coverage may be provided for an unmarried Dependent Child who, regardless of age, is incapable of self support, and became disabled before age nineteen (19), because of

- Mental illness,
- Mental retardation,
- Developmental disability, or
- Physical handicap.

To be eligible, the subscriber must provide proof of disability and dependency within thirty-one (31) days of the child's nineteenth birthday, or at time of enrollment if the child is already age 19 or older, by submitting a *Handicapped Dependent Form* completed by the dependent's attending physician. Please contact Member Services for a copy of this form (a copy is included in the forms section of this manual).

## *Ineligible Dependents*

The following dependents are not eligible to enroll for coverage:

- An ex-spouse. If a court decree requires one ex-spouse to cover the other, the ex-spouse's only option is an Individual policy or under a separate COBRA policy if eligible.)
- An employee's parents
- Married children
- A child or spouse on active duty in the armed forces of any country except for temporary duty of 31 days or less
- Children who are past the plan's maximum age provisions (unless physically or mentally disabled)
- Grandchildren and stepchildren (unless they meet eligibility requirements previously described)
- Sisters or brothers (unless Subscriber is appointed the legal guardian by the court and may claim the sibling as a dependent on their federal income tax return and all other eligibility requirements are met)
- A stepchild or other child of whom the employee has legal guardianship, but who receives less than one-half of his or her support from the employee. (This does not apply to a natural child, a legally adopted child or a child who has been placed in the employee's home for the purpose of adoption.)
- Any spouse or child who is eligible for Medicare, by reason of age (except, when the employee remains employed on a full-time basis, the spouse may be entitled to remain covered as a Family Dependent)

**Note!** If a Subscriber is enrolling a dependent child who is not their natural child, a copy of the legal documents provided by the court is required.

## *When Employees and Their Dependents are Eligible to Enroll*

Employees and their dependents that meet the eligibility requirements outlined above are eligible to enroll at the following times:

- **Initial Group Enrollment Period**
- **Newly hired employees**, during the eligibility period following the group's waiting period
- **Late Entrants** – individuals who did not enroll for group coverage at the initial enrollment and do not have a qualifying event (i.e. marriage, birth, adoption,

placement for adoption or expiration of COBRA), are only allowed to enroll at the group's Open Enrollment Period (the month prior to the group's annual renewal date).

- **Special Enrollment** -The period during which a Subscriber and/or Family Dependent may elect to enroll as outlined below:
  1. If an employee and/or family dependent(s) are otherwise eligible for coverage and they did not enroll in the employer group benefit plan during the initial enrollment they may be eligible for Special Enrollment described below.
  2. Employees and/or family dependent(s) who initially decline coverage within the first thirty-one days (31) of the date they became eligible.
    - a. If an employee and/or their Family Dependent(s) are otherwise eligible for coverage but declined enrollment within the first thirty-one (31) days of the date they became eligible to enroll, the employee may enroll during a Special Enrollment Period. Such enrollment is effective on the Effective Date of Special Enrollment, provided the following conditions are satisfied:
      - (1) When coverage was declined, the employee stated in writing that coverage under another group health plan or other health insurance coverage was the reason for declining enrollment
      - (2) The other coverage was COBRA continuation coverage under that other group health plan and such coverage has been exhausted
      - (3) The other coverage was terminated as a result of loss of eligibility for the coverage or employer contributions towards the other coverage have terminated
      - (4) The employee or their dependent requests such enrollment not later than thirty-one (31) days after the date of exhaustion or termination of the credible coverage.
    - b. The Special Enrollment Period is the period ending thirty-one (31) days after the exhaustion of COBRA coverage or the termination of the other coverage as a result of loss of eligibility or cessation of employer contributions toward the other coverage.
    - c. The Effective Date of Special Enrollment is the first day of the first calendar month beginning after the date the Enrollment Form is received by the Policyholder or the day after the other coverage terminated if allowed by the employer and if the employer receives the enrollment form within thirty (30) days of the termination.
  3. New Family Dependents
    - a. If an employee is enrolled and has a new dependent as a result of a

marriage, birth, adoption of a child, or the placement of a child for adoption, the employee may enroll the new family dependents during a Special Enrollment Period. The enrollment is effective as of the Effective Date of Special Enrollment. **NOTE: Newborns and adopted children are automatically covered for thirty-one (31) days after birth, or adoption, or placement in the home for adoption. To continue coverage beyond thirty-one (31) days, unless the employee is already enrolled under the Family Membership Plan, the employee must apply for coverage by submitting an Enrollment/Change form to the Policyholder within the thirty-one (31) day period.**

- b. If an employee and/or their spouse are not enrolled and have a new Family Dependent, provided the employee and their spouse are otherwise eligible, then (i) the employee, (ii) the employee and their spouse, or (iii) the employee, spouse and the new Family Dependent, may enroll during a Special Enrollment Period. The enrollment is effective as of the Effective Date of Special Enrollment.
- c. For purposes of this subparagraph 3, the Special Enrollment Period is the thirty-one (31) day period beginning on the date of the marriage, birth, adoption or placement for adoption of the new family dependent.
- d. For purposes of this subparagraph 3, the Effective Date of Special Enrollment is:
  - (1) In the case of marriage, the first day of the calendar month after the date the enrollment form is received by HPS or the date of marriage if approved by the Policyholder and the Enrollment Form is received by HPS within thirty (30) days of the marriage
  - (2) In the case of the Family Dependent's birth, the date of birth; In the case of the Family Dependent's adoption or placement for adoption, the date of such adoption or placement for adoption.

In all cases of a change in eligibility or dependent status the employer must notify HPS within ten (10) business days from receipt of such information from the employee or dependent.

**Open Enrollment Period** -The annual period during which AAHPS and the Policyholder agree that Subscribers and eligible Family Dependents may apply for coverage. Subscribers and Dependents may also be able to enroll during special enrollment periods. **This period is the month preceding the annual renewal date.** Coverage is effective the first of month following the Open Enrollment Period.

## *Employees Declining Coverage*

If an employee refuses or declines coverage for himself/herself please have them complete the ***Waiver of Coverage*** form and return it to HPS. Employees and or their eligible dependents are prohibited from enrolling in the plan unless they qualify under the Special Enrollment provisions.

## *Enrolling New Hires*

As new employees join your company you will want to give them all the information they will need to make an informed decision regarding their healthcare benefits. Once the new employee has met your waiting period, he or she may enroll in the HPS plan (assuming all other eligibility requirements are met).

### **New Hire Packets**

Packets of information that can be presented to new hires either alone, or in addition to other materials you may have, are available for your company. This packet contains several informational pieces:

- Provider Listing
- Benefit Summary
- Enrollment Form
- PCP Information

If you do not have any of these packets for new hires, please contact the Sales Department.

### **New Member Packets**

Health Plan Select will mail New Member Packets to each employee that enrolls. These packets include the HPS Evidence of Coverage, a Provider Directory, a Benefit Summary, applicable rider information, and Identification (ID) Card(s). Every effort is made to ensure the enrollee receives these packets on or before the effective date.

Members should carry their ID card with them at all times; these cards are necessary for making appointments, obtaining prescriptions, during visits to the physician's office, and for identification in emergency situations and hospital admissions. HPS will issue one card per member.

### **Temporary Identification**

The Subscriber's copy of the *Enrollment Form* (pink copy) will serve as a temporary form of identification until the permanent ID cards are received. The use of the temporary ID may require the provider to call HPS Member Services to verify eligibility and benefits.

## *Consumer Choice Option*

The Consumer Choice Option (CCO) is a state law that allows members of managed care companies to select their own physicians. Members who enroll in the CCO plan can receive in-network healthcare services from out-of-network providers.

If your employees require additional information they should contact the Sales Department at (706) 549-0549 or 1-800-293-6260.

## *Condition Of Coverage*

When the employee submits an Enrollment/Change Form and pays premiums, they accept the terms of the Contract, including the obligations, benefits, limitations and exclusions of the Contract.

### III. USING YOUR COVERAGE

#### *Member Identification Cards*

Every effort should be made to have your employees' enrollment application(s) to Health Plan Select prior to the effective date of coverage. It is our goal to provide identification cards and welcome packets to newly covered employees within 5-10 business days after receipt of the application(s). Timely submission of the documents will help to ensure your employees receive their ID cards before coverage is effective.

Each eligible member listed on the contract will receive his/her own ID card and will be eligible for services from his/her health care provider. Possession of a Membership Card does not guarantee eligibility for medical coverage. Benefits and eligibility will be determined at the time claims are received. Verification of coverage prior to receiving services can be obtained through contacting the Member Services Department at HPS.

The member ID card is the "ticket" your employees will use to receive services covered by their health plan. Your employees should carry their member ID card at all times and present it to health care professionals whenever they are seeking treatment or service. The ID card specifies the employee's entire health care benefits plan, including medical, pharmacy, dental, mental health, as applicable to your group's specific plan.

Member ID cards are to be used only by members of health care plans offered or administered by HPS. Use of a HPS member ID card by anyone other than the member named on the card for the purpose of receiving services constitutes fraud. Penalties for fraud include immediate termination of coverage and criminal prosecution.

The image shows a sample Health Plan Select member ID card. The card has a red header with the text "HEALTH PLAN SELECT" and two phone numbers: (706) 549-0549 and (800) 293-6260. Below the header, the card lists member information: MEMBER NAME: MEMBER, JOHN Q; MEMBER ID#: 12345678901; RELATIONSHIP: SUBSCRIBER; EFF. DATE: 01/01/2007; SUBSCRIBER NAME: MEMBER, JOHN Q; PCP: HPS PAR, PROVIDER; GROUP: A9999 - ABC CORPORATION; PLAN: H353 / HMO; COPAY: PCP: \$15, ER: \$100, Specialist: \$30, Urgent Care: \$25, Hospital: \$300, Mental Health: \$30; PRESCRIPTION DRUG BENEFITS: RXBIN: 003585, PCN: 11200, MedImpact/MedCare, RX-G/P/NP: \$15/\$25/\$50. At the bottom, there are logos for "Medical Networks" (including AMN and GlaxoSmithKline) and "H P S" (Health Plan Select) with "Wooch Street Corporation" and "Wooch Georgia C. Deane Corp." listed below. A callout box on the right side of the card points to various fields with the following descriptions: "Employee's member specific information including name, member ID, employer name and group number." (points to member name and ID), "Employee's coverage effective date." (points to EFF. DATE), "Employee's designated Primary Care Physician (PCP)" (points to PCP), "Medical plan information including copays (PCP, Specialist, Inpatient, ER, Urgent Care and Mental Health office visit)" (points to copay and benefit amounts), "Pharmacy copays" (points to RX-G/P/NP), and "HPS network affiliations for discounts" (points to the logos and company names at the bottom).

#### *Choosing a Doctor or Hospital*

In-network? Participating? Preferred? The different names that health plan companies use to categorize doctors, hospitals and other health care professionals can create a lot of

confusion for your employees. We use the following terms to describe our relationships with health care professionals:

**“Network”** or **“In-network”** denotes those health care professionals in our 18 county service area (**Local Network**) who have an agreement with us to provide care to our members. Prior authorization is not required from HPS to see “In-network” specialists.

**“Out-of-network”** indicates those health care professionals who do **not** have an agreement with us to provide care to our members. Covered members on an HMO plan are required to obtain prior authorization before seeking treatment from an “Out-of-network” provider. POS members may use their “Out-of-network” benefits to access these providers without prior authorization.

**“1st MN”** 1st Medical Network (1st MN) is the largest provider-owned PPO network in the state of Georgia. HPS has an agreement with 1<sup>st</sup> MN to use their network as a “wrap network” to cover those areas of specialty providers that are not available in our local 18 county service area. 1<sup>st</sup> MN provides HPS members the ability to access more than 15,000 physicians, 150 community-based hospitals and academic medical centers and ancillary service providers in the state of Georgia. **HMO members must receive written prior authorization from HPS** for services to be covered as “In-Network”. Access to these providers is only granted when the needed service is not available in our local service area. POS members may access care from a 1<sup>st</sup> MN provider through their out-of-network benefits. In-network benefits for POS members would require prior authorization from HPS.

**“Beech Street”** is a comprehensive “wrap network” that provides access to more than 400,000 respected practitioners, 3,800 hospitals and over 52,000 ancillary network providers throughout the United States. HPS utilizes this network for discounts for emergent or prior authorized care received by members outside the state of Georgia. Utilizing the network discounts ultimately saves on the overall cost of providing healthcare to your employees. Members may not directly seek care from Beech Street providers for non-emergent care without written prior authorization from HPS.

## *Network FAQ's*

**QUESTION: How can my employees find out if a particular doctor is in the network?**

**ANSWER:** There are three ways to determine if a doctor, hospital or other health care professional is in the network:

- Look for the doctor’s name in online provider director at [www.aahps.com](http://www.aahps.com). The online provider directory is updated monthly.
- Look for the doctor’s name in the hard-copy Provider Director included in the Member Enrollment Packet – if you do not already have a directory, you can request one from your Account Manager or Member Services.
- Call a Member Services Representative at (706) 549-0549 or 1-800-293-6260.

**QUESTION: Do members in my group have to use an in-network health care professional in order to receive coverage?**

**ANSWER:** HMO members are required to use health care professionals within our **local network** for elective, non-emergent care. If you have a POS plan you have the freedom to visit any health care professional but you will pay more if you use out-of-network providers. For specific details regarding your group's ability to receive coverage outside of the network, please see your Evidence of Coverage provided in the document section of this manual.

**QUESTION: What about emergency care received at an out-of-network hospital?**

**ANSWER:** True emergency care is covered no matter where the services were received. An emergency is described as a medical condition of a recent onset and sufficient severity, including but not limited to, severe pain that would lead a prudent layperson, possessing an average knowledge of medicine and health, to believe that his or her condition, sickness, or injury is of such a nature that failure to obtain immediate medical care could result in:

- placing the patient's health in serious jeopardy, or
- serious impairment to bodily functions, or
- serious dysfunction of any bodily organ or part, or
- with respect to a pregnant Member who is having contractions, that there is inadequate time to safely transfer her prior to delivery or that such transfer may pose a threat to the health or safety of the Member or her unborn child.

If a member of your group ever needs true emergency medical care as described above, he or she should go immediately to the nearest medical facility. HMO and POS members who receive emergency treatment should notify Member Services within 48 hours after receiving care to ensure proper handling of the emergency room claim. Members can also contact our 24-hour Nurse Line at 1-800-337-4770 for assistance. Referrals to the ER by the Nurse Line are automatically reported to HPS for approval.

Members are required to pay their emergency room copay at the time of service. This copay is waived if the member is admitted to the hospital.

Follow-up care for Emergency treatment must be received from an In-Network Provider whenever possible for benefits to be paid.

**Note: If emergency care is received from an out-of-network hospital and a network hospital was reasonably available in the same area such that there was no Medical Necessity to receive treatment from the out-of-network hospital, HPS will apply the UCR (usual, customary, and reasonable) limits for the out-of-network treatment. UCR can dramatically reduce the payment made by HPS for the services provided leaving members with the potential for significant financial liability.**

## *Coordination of Benefits (COB)*

Coordination of benefits applies to members of your group who are covered by more than one health care plan. Coordination of benefits helps ensure that members covered by more than one plan will receive the benefits they are entitled to while avoiding overpayment by either plan. Coordinating benefits is one of the ways we work to keep premiums at a minimum.

### **How COB Works**

When a member of your group is covered by more than one health plan (for example, when one of your employees is covered under your group plan as well as a spouse's health plan), one plan is considered to be the primary carrier and the other is considered to be the secondary carrier. The primary carrier covers the major portion of the bill according to plan allowances, and the secondary carrier covers any remaining allowable expenses.

The COB provisions of your policy or plan determine which plan is primary. That plan's benefits are applied to the claim first. The unpaid balance is usually paid by the secondary plan to the limit of its responsibility. Benefits are thus "coordinated" among all of the health plans, and payments do not exceed 100% of allowed charges for the covered services.

### **Primary vs. Secondary**

The following rules apply when determining which insurance plan is primary:

- Any plan without a COB provision always pays first.
- If the person receiving benefits is the subscriber under the contract, that health plan will be primary. The spouse's health plan will become secondary.
- If a dependent child is covered by two (2) or more health plans, the plan of the parent whose birthday falls first in the calendar year will be primary. This rule is known as the ***Birthdate Rule***. If the parents have the same birthday, the plan that has the earliest effective date will be the primary plan. The birthday rule is superseded when a **court order or custody rule** applies.

### **Dependent Coverage When Parents Are Divorced**

If the dependent is a child of divorced or separated parents, primary payer status is determined according to the following:

- If the divorce decree places responsibility on one parent, that parent's health plan is primary.
- If the divorce decree states both parents have equal responsibility, the custodial parent's plan is primary and the other parent's health plan becomes secondary.

- If there is joint custody, the birthday rule applies and the health plan of the parent whose birthday occurs earlier in the calendar year is primary.

### **Other COB Issues**

Often, some or all of the costs of medical care are the responsibility of an insurance party other than HPS:

- Members who are injured or become ill as a result of work-related accidents or environment are eligible for benefits under the Workers' Compensation Law. HPS excludes coverage for treatment for or complications of any injury or illness which is or would be covered by Workers' Compensation laws if a claim was filed, or that is an occupational or on-the-job injury or sickness which is the result of or related to the employment or occupation of the member.
- HPS will not pay for benefits if coverage would be available to the member under government programs, with the exception of Medicaid.
- In certain situations, Medicare may be a participant's primary or secondary coverage. HPS will coordinate benefits with Medicare according to the Medicare Secondary Payer rules.

### **Medicare Secondary Payer (MSP) Rules**

#### **How benefits are paid:**

Medicare is a nationwide government-sponsored health plan that covers certain medical expenses for persons who are entitled to benefits due to their age or due to disability. Medicare Part A covers certain inpatient medical expenses, and Part B covers certain outpatient medical expenses.

The federal "Medicare Secondary Payer" (MSP) rules require that, for persons covered under both Medicare and a group health plan, Medicare must be the secondary payer in certain situations. This means that the group health plan must not take Medicare entitlement into account when:

- Determining whether these individuals are eligible to participate in the plan, or
- Providing benefits under the plan.

It is very important for your group to understand the MSP rules and how they apply to you. The rules generally apply based on the number of employees, but there are specific rules that determine how employees are counted and during what time period. It is the employer's responsibility to determine whether its plan is primary to Medicare under the MSP rules, and this is not a determination your insurance carrier or self-funded plan administrator can make on your behalf.

**The information in this Group Administrator Manual is very general in nature and it is only intended to describe the basic workings of the MSP rules. The MSP laws and regulations may change from time to time, so it is important for you and your company's legal counsel to review them periodically to ensure compliance.**

Additional information about the MSP rules can be found on the Web site of the Centers for Medicare and Medicaid Services (CMS), the federal agency that administers these programs, at <http://www.cms.hhs.gov/MedicareSecondPayerandYou>.

### **Medicare Secondary Payer Demands (MSP Demand)**

If your company receives correspondence related to one of your employees from the **Centers for Medicare & Medicaid Services** requesting repayment of claims paid, please contact the Member Services Department at (706) 549-0549, ext. 6360. It is important to respond to these requests for information as soon as possible so that claims can be reviewed in a timely manner and repayment or a written response regarding the case can be forwarded to CMS. Failure to comply with the MSP Demand can result in a lien being placed against your company by the Department of the Treasury.

### **Basic Information about the MSP Rules**

**The MSP rules do not apply to persons who may be covered under your plan as retirees.** For other covered employees or dependents that are eligible for Medicare, however, the following MSP rules are applicable.

#### **Employer groups of 20 or more employees:**

If your company has 20 or more employees, your group health plan must provide the primary coverage for:

- Covered active employees who are entitled to Medicare because they are age 65 or older, and
- Covered spouses who are entitled to Medicare because they are age 65 or older, regardless of the age of the covered employee.
- "Attain" age 65 on the day before his or her 65th birthday, and
- Be "age 65 or older" beginning on the first day of the month in which he or she "attains" age 65.

For MSP purposes, a person is considered to: For example, a person whose 65th birthday is July 2 is considered to be "age 65 or older" beginning on July 1. A person whose 65th birthday is July 1, however, is considered to be "age 65 or older" beginning on June 1. For these covered persons, your group health plan benefits must be paid before Medicare benefits.

#### **Employer groups of 19 or fewer employees:**

If your company has 19 or fewer employees, Medicare is the primary coverage for:

- Covered active employees who are entitled to Medicare because they are age 65 or older, and
- Covered spouses who are entitled to Medicare because they are age 65 or older, regardless of the age of the covered employee.

### **Employers subject to the MSP rules include:**

- Organizations or individuals (including self-employed persons) carrying on trades or businesses,
- Entities that are exempt from income tax, such as religious, charitable and educational institutions, and
- Governments, government agencies, instrumentalities, and political subdivisions, including federal, state and local governments.

### **When Medicare is primary regardless of the MSP rules**

In certain situations, Medicare provides the primary coverage notwithstanding the MSP rules. These situations include those in which:

- A Medicare-entitled person refuses coverage under the group health plan;
- Medical services or supplies are covered by Medicare but are excluded under the group health plan;
- A Medicare-entitled person has exhausted his or her benefits under the group health plan;
- A person entitled to Medicare for any reason other than ESRD (End Stage Renal Disease) experiences a COBRA qualifying event and elects COBRA continuation;
- A person who was on COBRA becomes entitled to Medicare for a reason other than ESRD, and his or her COBRA coverage ends.
- Despite the MSP rules, the law does not force an employee to accept coverage under his or her company's group health plan. If an employee who is entitled to Medicare refuses coverage under your employer plan, Medicare will be the primary payer. In this situation, your plan is not allowed to provide any benefits to supplement the individual's Medicare benefits.

### **Disability**

Medicare is secondary payer for claims for covered persons **under age 65** who have Medicare because of a disability and who are covered under a Large Group Health Plan (LGHP) through their current employment or through the current employment of any family member. **An Employer Group Health Plan (EGHP) that covers employees of at least one employer that has 100 or more employees, on 50 percent or more of its business days during the preceding calendar year, meets the definition of an LGHP.** LGHPs include plans sponsored or contributed to by an employer or employee organization, such as a union, as well as plans in which employees pay all the costs. Once a disabled person attains 65, their status changes to “age entitled beneficiary”.

### **End-Stage Renal Disease/Permanent Kidney Failure**

Medicare is secondary payer to an EGHP during a 30-month coordination period for beneficiaries who have Medicare because of permanent kidney failure. This rule applies

to both those with permanent kidney failure who have their own coverage under an EGHP and to those covered under an EGHP as dependents. Additionally, this rule applies without regard to the number of employees or to the enrollee's employment status.

## *How You Can Help With COB Savings*

Current, accurate benefit information is essential to making sure the members in your group get the full advantage of their benefits and avoid delays in claims payments. To help coordination of benefits go as smoothly as possible for the members in your group, you can:

- Explain to the members in your group the importance of providing complete COB information on their Member Enrollment Applications.
- Let members know they should promptly respond to requests for COB information mailed out by HPS. Claims are denied until the request for COB information is received.

## *Claims and Appeals*

One of the most convenient aspects of having coverage under our health plans is that there are virtually no claim forms for members to file when they receive care from in-network providers and show their member ID card. Participating network providers file claims directly to HPS for the services and reimbursement is made directly to them. The member typically pays their co-payment and/or co-insurance at the time services are rendered. This process works the same for prescription medication if your group has purchased the pharmacy rider.

### **When Members May be Required to Manually File a Claim**

Your employees may have to pay for services and file a claim if they:

- Do not present their member ID card when services are received or
- Receive treatment from an out-of-network doctor, hospital or other health care professional (i.e., emergency services or those services needed while traveling out of the service area for vacation – trips lasting no longer than 30 days).

A copy of our medical and dental claim forms are attached in the forms section of this manual.

For claims filed by members, reimbursement checks and Explanations of Benefits (EOBs) are mailed directly to the member. It is his or her responsibility to pay the health care professional, if applicable.

Additionally, if your group's plan provides coverage for services received out-of-network (POS), the out-of-network health care professionals may **balance-bill the member for those amounts that exceed HPS's Usual, Customary, and Reasonable (UCR) allowance.**

### **Prescription Drug Claims**

HPS has contracted with a Pharmacy Benefit Manger (PBM) to manage the prescription drug program for our covered members. The member's ID card includes the prescription drug plan information.

When a member of your group presents his/her member ID card at an in-network pharmacy and pays the appropriate copay at the time the prescription is filled, the pharmacy will file a claim directly on the member's behalf. If a member does not show his/her member ID card or if the pharmacy is not in our network, the member may need to pay for the prescription in full and then present the receipt(s) and a written explanation of the claim to Member Services for reimbursement. The amount reimbursed may be less than the amount the member paid since co-payments and/or deductibles are required for covered drugs. Prescription drug claims must be filed within 12 months of the date the prescription was filled.

### **Dental Claims**

If your group has enrolled in one of HPS's dental plans, it is important to know that we currently do not have specific dentists that participate in our plan. Since HPS has a good reputation in the community for timely claims payment, some local providers may be willing to file claims for covered members. In most cases, however, your employees will likely be required to submit a completed claim form and attach their itemized bills for reimbursement of covered services. Each itemized bill must contain the following information:

- Name of the patient receiving services or supplies
- Dental professional's name and address
- Date services or supplies were provided
- Charge for each type of service or supply
- Description of the services received
- A description of the patient's condition (routine treatment, emergency service, or accidental injury)

### **Filing an Appeal – Review of a decision made by Health Plan Select**

As a Health Plan Select HMO, POS, or PPO member, your employees have the right to express dissatisfaction and expect unbiased resolution of their issues. The following explains the process established to ensure that HPS gives its full attention to a member concerns. Employees can use these procedures to tell us about concerns when they are not satisfied with any aspect of our services they receive.

**IMPORTANT NOTICE:** For purposes of this section, a Medical Appeal concerns questions of medical treatment, Prior Authorization, Medical Necessity, length of stay, and other issues involving medical judgment. All Medical Appeals will be reviewed by a medical doctor(s) or other licensed medical professional who was not involved in the non-certification (including his or her subordinates), who is board certified (if applicable), and is of the same or similar specialty as typically manages or treats the medical condition in question. All second level Appeals will be decided by the Review Panel.

Complaints are any expression of dissatisfaction with the health plan and include Administrative Appeals which concerns exclusions or limitations of treatments or services, eligibility issues, and other matters which do not involve medical judgments. All Complaints and Administrative Appeals will be decided by a non-medical Appeals Committee.

Members can contact the Member Services Department at (706) 549-0549, extension 6360 or toll free, 1-800-293-6260 and tell us about their problem. We will work to resolve it as quickly as possible. Members should be prepared to provide us the following information:

- Member's identification number;
- Member's name and address;
- Date(s) of Service; and
- Provider's name.

**MEDICAL APPEALS:** If members are not satisfied with our answer concerning a medical issue, they may file a formal Appeal. We prefer this Appeal be in writing, however, members may submit their Appeal verbally or via Email. The formal appeal should be forwarded to the address below:

Attention: Appeal Coordinator  
Athens Area Health Plan Select, Inc.  
295 W. Clayton Street Athens, GA 30601  
E-mail: **memberservices@aaahps.com**

1. You should receive a written acknowledgement from the Appeal Coordinator within five (5) working days following receipt of your request. You or your physician can request an expedited Appeal if it reasonably appears that failure to receive the proposed care or treatment would seriously jeopardize the life or health of a Member, jeopardize the Member's ability to regain maximum function, or subject the Member to severe pain that cannot be adequately managed without the proposed care or treatment. At the conclusion of this formalized review of your concern, a final written response will be sent to you, which will hopefully resolve your issue.
2. Any Complaint regarding care issues will be referred to the Quality Department for immediate investigation and resolution, with communication of the status to

the Complaint Coordinator prior to the fifteenth (15<sup>th</sup>) working day after the appeal was acknowledged.

3. If the member remains dissatisfied upon the completion of the first Appeal level, they may again request an Appeal of the decision. At the second Appeal level, the member has the opportunity to represent him/herself in a formal Appeal Committee setting to present their position.
4. The Appeals Coordinator will issue a written decision to following the Appeal Committee meeting and, if applicable, to the provider, within five (5) days. The decision will include:
  - a. The professional qualifications and licensure of the members of the review panel.
  - b. A statement of the review panel's understanding of the nature of the Appeal and all pertinent facts.
  - c. The review panel's recommendation to HPS and the rationale behind that recommendation.
  - d. A description of or reference to the evidence or documentation considered by the review panel in making the recommendation.
  - e. In the review of a non-certification or other clinical matter, the medical doctor(s) or other healthcare professionals will provide a written statement of the clinical rationale, including the clinical review criteria, that was used by the medical doctor(s) to make the recommendation. See the "Important Notice" above.
  - f. The rationale for HPS' decision if it differs from the review panel's recommendation.
  - g. A statement that the decision is HPS's final determination in the matter.
  - h. A statement advising the Member of the right to request an external review.
  - i. A statement that the member may appeal to the Georgia Department of Insurance and/or the Georgia Department of Human Resources at the following addresses:

Office of Insurance and Safety Fire Commissioner  
Consumer Services Division  
Seventh Floor, West Tower  
Floyd Building  
2 Martin Luther King Jr. Drive  
Atlanta, Georgia 30334.

Georgia Department of Human Resources  
Complaint Intake Unit 2  
Peachtree Street, NW 32<sup>nd</sup> Floor  
Atlanta, GA 30303

**COMPLAINTS AND ADMINISTRATIVE APPEALS:** If you are not satisfied with our answer concerning a non-medical issue, you may file a formal Administrative Appeal. We prefer this Administrative Appeal be in writing, however, you may submit your Administrative Appeal verbally or via Email. Your formal Administrative Appeal for further review of your concerns should be forwarded to the address below:

Attention: Complaint Coordinator  
Athens Area Health Plan Select, Inc.  
295 West Clayton Street  
Athens, Georgia 30601

Administrative Appeals about non-medical issues, such as dissatisfaction with the health plan, Exclusions and limitations of the plan, are reviewed by a committee composed of the Director of Claims, Director of Member Services, Director of Quality and Utilization, and the Director of Network Development. Any three of these constitute a quorum. Second Level Administrative Appeals are reviewed by the Appeals Committee, which is composed of the Executive Director, Chief Operating Officer, and the Chief Financial Office, which constitute a quorum.

The Appeals Coordinator will issue a written decision to you following the Review Panel meeting and, if applicable, to your provider, within five (5) working days. The decision will include:

1. The names and titles of the members of the Appeals Committee.
2. A statement of the Appeals Committee's understanding of the nature of
3. The Administrative Appeal and all pertinent facts.
4. The Appeals Committee's decision and the rationale behind that decision.
5. A description of or reference to the Evidence of Coverage or Group Healthcare Contract considered by the Appeals Committee in support of its decision.
6. A statement that the decision is HPS' final determination in the matter.
7. A statement that the member may appeal to the Georgia Department of Insurance and/or the Georgia Department of Human Resources at the following addresses:

Office of Insurance and Safety Fire Commissioner  
Consumer Services Division  
Seventh Floor, West Tower  
Floyd Building  
2 Martin Luther King Jr. Drive  
Atlanta, Georgia 30334

Georgia Department of Human Resources  
Complaint Intake Unit  
2 Peachtree Street, NW 32nd Floor  
Atlanta, GA 30303

If an Appeal or Complaint is made to the Georgia Department of Insurance, or the Department of Human Resources, that Department will provide a copy of the Appeal or Complaint to HPS. HPS will provide a written response within ten (10) working days to the requesting agency.

## IV. Member Termination and Conversion

This section of the Group Administrator Manual provides information to assist you with ending a member's coverage. This Group Administrator Manual provides general administrative information related to commercial health and dental plans offered by HPS. It is intended for use by Group Administrators, who are individuals designated by employers to handle routine administrative matters associated with the employer's group health insurance or dental policy or plan. It is not intended as legal or benefit plan consulting advice, but only as a convenient reference source for general administrative information.

### *Ending a Member's Coverage*

It's important to let us know immediately when coverage should be ended for an employee of your group or for a covered employee's dependent. Timely notification of termination is critical so that HPS can issue the required documents to terminating members so they can make important decisions related to extending coverage or enrolling with another employer plan.

Written notification of a covered member's termination can be done by completing a HPS Change Form. A copy of the change form is available on our web site or you can request a supply from our Sales Department by calling (706) 549-0549, ext. 6350. Please be sure to include the following information when completing the change form:

**Subscriber's Name** – this is the name of your employee

**Group Number** – your company's group ID – this can be found on your monthly billing statement or on any member's ID card.

**Section B** on the form should be completed in its entirety to include:

1. Employment termination date for employee or dependent (check appropriate box)
2. Reason for coverage termination, i.e., voluntary resignation, termination, divorce, coverage dependent, etc. (check appropriate box or use space provided for situations not listed)
3. Include date of change – HPS will provide coverage to the end of the month in which the change occurs unless you request otherwise. Your company will be billed for a full month's premium. Please remember that retroactive terminations will only provide a 2-month premium credit.

**Section D** – Please indicate if member wishes to continue coverage through the GA 90-day Continuation of Coverage for groups with less than 20 employees or COBRA Continuation of Coverage for groups with more than 20 employees. For additional

information on Continuation of Coverage please refer to the section below entitled Continuation of Coverage after Termination.

**Employee Signature** is only required for termination of a dependent's coverage if they elect to continue coverage under the GA 90-day Continuation of coverage or COBRA.

**Certificate of Creditable Coverage** must be provided in writing by the health insurance carrier to individuals who are no longer covered. When we are required to issue a certificate of creditable coverage, we will do so within the timeframe allowed by law.

Certificates of creditable coverage include certain identifying information about the individual and the plan, the date any waiting period for eligibility began, the date creditable coverage began and ended, and an educational statement regarding HIPAA.

When a participant's coverage is terminating (either due to termination of employment with your group or because his or her COBRA continuation coverage is ending), please make sure their correct address has been forwarded to us.

## *Continuation of Coverage after Termination*

### **Continuation of Coverage Under Georgia Law (90 Day)**

1. A Covered Employee whose coverage ends and who has been continuously covered under this Plan and any plan providing similar benefits which it replaces **for at least six (6) months**, may continue coverage for himself/herself and any covered dependents, subject to the following terms. Each Dependent has an individual right to continue coverage under this provision. The exercise of this Continuation of Coverage will not affect the conversion rights defined in Sections B and C below. Continuation of Coverage will not be available for:
  - a. Any person who is, becomes, or could be covered under Medicare; or
  - b. Any person who is, becomes, or could be covered as an employee, Member, or Dependent by any similar group coverage; or
  - c. Any person whose employment was terminated with cause; or
  - d. Any person whose coverage was terminated for failure to pay any required premium contribution; or
  - e. Any person whose coverage was terminated as a result of the Group Health Benefit Plan or a portion of the Group Health Benefit Plan being terminated.
2. If an employee wants Continuation of Coverage they must request this in writing by notifying the employer in writing, within the thirty-one (31) day period following the later of:
  - a. The date of termination; or
  - b. The date the employer gives them. In no event, however, may an employee elect continuation more than thirty-one (31) days after the date of coverage termination.

3. Continuation of Coverage must be requested in writing and the employee must pay the first month's premium and any retroactive premium charges for Continuation of Coverage to the employer within thirty-one (31) days after the date the coverage ends. The premium will be at the same rate as a member's whose coverage has not been terminated and should include both the member's premium contribution and the employer's premium contribution. Future monthly premium payments must be made in advance to the employer group. HPS will continue to bill the employer group for the applicable premium for any employees electing Georgia Continuation of Coverage.
4. Continuation of Coverage will end on the earlier of :
  - a. The expiration of the fractional policy month remaining and three (3) months after the end of employment or Membership; or
  - b. The end of the period for which premium payments were made. This will apply if premiums are not paid on time; or
  - c. The date on which the Contract with the Policyholder ceases.

The Conversion Privilege described in C below is available when any period of Continuation of Coverage under this paragraph ends. However, it will not be available if coverage ends due to nonpayment of premiums.

### **Frequently Asked Questions About Georgia Continuation of Coverage**

**QUESTION: My company has less than 20 employees and will be canceling all of the health insurance coverage for the company. Will our employees be eligible for Georgia Continuation?**

**ANSWER:** No. Since the plan is being completely cancelled there will be no coverage available. However, your employees may be eligible for conversion coverage. Please contact HPS for more information.

**QUESTION: Does the Georgia Continuation coverage count as Creditable Coverage under the HIPAA regulations?**

**ANSWER:** Yes. All Group and Individual policies count as Creditable Coverage.

**QUESTION: How long are my terminated employees eligible for coverage under Georgia Continuation?**

**ANSWER:** 3 months.

**QUESTION: How are the premiums collected for Georgia Continuation?**

**ANSWER:** As stated above, the premium will be at the same rate as a member's whose coverage has not been terminated and should include both the member's premium contribution AND the employer's premium contribution. Premium payments must be made to the employer group. HPS will continue to bill the employer group for the applicable premium for any employees electing Georgia Continuation of Coverage. **HPS DOES NOT bill your employees for this coverage.**

### **Continuation of Coverage Under Federal Law (COBRA)**

1. COBRA Continuation coverage may also be available under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). This law applies to employers that had at least twenty (20) or more employees on fifty (50%) percent of its typical business days during the preceding calendar year. COBRA is available to "Qualified Beneficiaries" (individuals who were covered under the group health plan on the day preceding the "Qualifying Event" as an Employee or Dependent) if any of the following "Qualifying Events" occur:
  - a. Voluntary or involuntary termination;
  - b. Reduction in hours that would result in loss of group health coverage;
  - c. Death of the Employee;
  - d. Employee becoming entitled to Medicare coverage;
  - e. Divorce or legal separation;
  - f. Dependent child ceasing to be a Dependent

**The Employee or Qualified Beneficiary must give the Employer or Plan Administrator notice within sixty (60) days of a divorce or legal separation (the sixty (60) days begins on the date of the entry of the divorce decree or legal separation by the court), a child reaching the limiting age, or the Employee becoming entitled to Medicare. Failure to give timely notice of these Qualifying Events will result in a loss of eligibility for COBRA continuation coverage.**

Continuation coverage for up to eighteen (18) months is available for the Employee in the case of termination of employment or reduction of hours. Continuation coverage for up to thirty-six (36) months is available for the Spouse or Dependent in the case of entitlement to Medicare, divorce or legal separation, or for the child ceasing to be a Dependent. Each Qualified Beneficiary has the same rights under the group health plan as a similarly situated active Employee including the right to add an eligible Dependent such as a newly adopted child to their coverage. COBRA continuation coverage may not be available to an Employee or Dependents if the Employee was terminated for gross misconduct. The Employer or Plan Administrator determines what constitutes gross misconduct. AAHPS does not determine what constitutes gross misconduct.

COBRA continuation coverage ends:

- a. At the end of the eighteen (18) month period for voluntary or involuntary termination or reduction of hours;
- b. At the end of twenty-nine (29) months for voluntary or involuntary termination or reduction of hours and the individual is determined to be eligible for Social Security disability benefits;
- c. At the end of thirty six (36) months for individuals whose coverage ended because of the death of the Employee, divorce or legal separation, a child ceasing to be a Dependent, or the Employee's entitlement to Medicare;
- d. If premium is not timely paid coverage will end at the expiration of the grace period for making premium payments to the Plan;
- e. The date on which the Qualified Beneficiary becomes covered under another group health plan that does not contain any exclusion or limitation with respect to a pre-existing condition;
- f. On the date the Qualified Beneficiary becomes entitled to Medicare;
- g. On the date the Employer ceases to maintain any group health plan;
- h. In the case of an individual who is receiving the eleven (11)-month Disability Extension, coverage may terminate the month that begins more than thirty (30) days after the date the final determination is made by Social Security that the individual is no longer disabled.

Premium for COBRA continuation coverage is One Hundred Two (102%) percent of the premium that would be applicable if the individual was still covered under the Plan as an employee or dependent. If only a Spouse or Dependent child is covered under COBRA they will be charged 102% of the premium applicable to an active employee of the same age and gender. For individuals who are determined to be eligible for Social Security disability benefits and receive the additional eleven (11) months of coverage the premium is One Hundred Fifty (150%) percent of the applicable premium. Non-disabled family Members can also be charged 150% of applicable premium if the disabled individual is covered under COBRA.

Once an individual has elected COBRA continuation, the initial premium payment must be paid within forty five (45) days after the date that the COBRA enrollment form was signed. All premiums back to the termination date are due at that time. The employee or dependent on COBRA continuation coverage is responsible for paying the premium in a timely manner each month. After the initial payment is made, each subsequent payment is generally due on the first day of each month. The COBRA enrollee has a thirty (30) day grace period to pay the monthly premium. The payment must be postmarked within the thirty (30) day grace period. The premiums must be paid within the grace period or coverage will be terminated. Eligibility for coverage with the health plan will not be updated until payment is received.

Notice must be given by the Employer of an individual's right to COBRA continuation coverage upon the occurrence of a Qualifying Event. As the employer, you are responsible to know and understand the regulations of COBRA. HPS currently provides

COBRA administration services through a third party company. If you would like information on this added benefit, please contact the Sales Department.

2. Family Medical Leave Act (FMLA). If your company is subject to the FMLA your employees have the right to Continuation of Coverage under the Group Health Benefit Plan if they take leave under FMLA.

### **Continuation of Coverage for Terminating Employees 60 and Over**

1. A Member who is sixty (60) years of age or more on the date his or her continuation coverage under Georgia Continuation or COBRA continuation coverage begins and who has been covered under this Plan for at least six (6) months, may elect to continue his or her coverage if coverage terminates after the continuation period or the COBRA continuation period.
2. A Member will not be entitled to continue coverage if:
  - a. Termination of employment is voluntary for other than health reasons;
  - b. Termination of coverage occurred because the employment of the Member was terminated for reasons, which cause a forfeiture of unemployment compensation under Chapter 8 of Title 34, the "Employment Security Law";
  - c. Termination of coverage occurred because the Member failed to pay any required contribution;
  - d. Any discontinued coverage is immediately replaced by similar coverage; or
  - e. The Group Healthcare Contract or group Plan was terminated in its entirety or was terminated with respect to a class to which the group Member belonged.
3. The surviving spouse or divorced spouse, if age sixty (60) or over, of a Covered Employee may continue coverage under this provision under the same terms and conditions as a Member.
4. The premium for this continuation coverage shall be One Hundred Twenty (120%) percent of the amount that would be charged if the individual was a current Member.
5. This right to continue coverage will terminate upon the earliest of the following:
  - a. The failure to pay premium or any required premium contributions, when due, including any grace period;
  - b. The date the Group Plan is terminated for all Members, except that if a different plan is offered to current Members, it must also be offered to the individual whose coverage is being continued under this Paragraph;
  - c. The date the individual whose coverage is being continued becomes covered under any other group health plan; or

- d. The date the individual whose coverage is being continued becomes eligible for Medicare coverage.
6. This provision (Continuation of Coverage for Those 60 Years or Age and Over) shall only apply to Employers whose plan covers twenty (20) or more Employees.

### ***Conversion Privilege - Direct Payment.***

NOTE: Employees must have exhausted any applicable continuation rights as set out above before being eligible for Conversion coverage. Two types of conversion coverage are available to “Qualifying Eligible Individuals” who live in Georgia and have eighteen (18) months or more of credible coverage, and are not eligible for coverage under Medicare or Medicaid, or for continuation of coverage under COBRA or state continuation laws. Qualifying Eligible Individuals whose coverage has terminated for any reason other than fraud or failure of the Qualifying Individual to pay a required premium contribution may elect either the Enhanced Conversion Option or the Basic Conversion Option. Individuals who are not Qualifying Eligible Individuals and whose coverage has been terminated for any reason other than eligibility for Medicare or failure of the Member to pay a required premium contribution and who have been covered under this Plan or the plan it replaces for at least six (6) months may elect only the Basic Conversion Option as described below.

**Enhanced Conversion Option:** The Enhanced Conversion option is comparable to the coverage offered under comprehensive health insurance coverage offered in the individual market in Georgia or comparable to the standard option of coverage available under the group or individual health insurance laws of Georgia. Qualifying Eligible Individuals must exercise their right to elect their conversion right within sixty-three (63) days of receiving notice of such right.

**Basic Conversion Option:** Both Qualifying Eligible Individuals and other Members are eligible to convert to a Basic Conversion Option. This is a more limited benefit plan which offers the same benefits provided by the most common Individual Conversion Agreement being offered by AAHPS, effective as of the date of termination of the Group coverage (which includes the period of Continuation of Coverage, if any), upon submitting a timely application for such coverage within thirty (30) days of receiving notice of their right to exercise their conversion right.

A full description of the benefits and premium for each type of conversion plan will be provided with the notice concerning conversion rights. The initial premium for the converted policy for the first month must be paid at the time the conversion right is elected. The premium and subsequent renewal premium shall be determined in accordance with Georgia law.

Your employees will be eligible to continue their Individual Conversion Agreement coverage only as long as they are not covered by, or eligible for coverage by another substantially similar insurance policy, prepaid plan, or other health benefit plan, or program offered by any party, including the federal, state or local government, which together with the Individual Conversion Agreement, would result in overinsurance or duplication of benefits according to standards on file with the Department of Insurance.

The Individual Conversion Agreement coverage will terminate when they become eligible for Medicare coverage by reason of age.

**Individual Conversion Coverage is offered through a company designated by HPS for this type of coverage. Individual Conversion is not a continuation of any HMO, POS or PPO plan offered by HPS.** Please contact Member Services for information on this product.

## V. BILLING

### *Paying Your Monthly Premium*

You will receive a Monthly Premium Invoice from HPS approximately 10 days before the first of each month. Your premium payment is due on or before the first day of the month for which Covered Services are to be provided. If payment is not received by the due date, we will send you a reminder notice. Your coverage will be terminated if we do not receive payment within 31 days of the due date. Payments must be postmarked by the last day of the month due.

Promptly remit payment to: Health Plan Select  
P. O. Box 7336  
Athens, GA 30604

If coverage is terminated for non-payment of premiums, the employer group will be responsible for repayment of all charges for services and supplies received by their employees following termination effective date. In addition, if your group wishes to be reinstated, medical underwriting will be required.

Your group Monthly Premium Invoice provides you with much more information than just the amount your company owes for the employee coverage. We ask that you take time each month to perform an audit of your employees to ensure the coverage you are being billed for is correct. If any discrepancies are noted, please indicate them on the bill and remit amended amount. Changes noted on your Monthly Premium Invoice will not be accepted unless accompanied by a completed, signed Change Form. Remember any changes made on your group's enrollment after the 15<sup>th</sup> of the month will be adjusted on the premium billing of the following month.

You may also receive a copy of your Monthly Premium Invoice via your email. Contact the Finance Department at 706/549-0549 Ext. 6307 for an authorization form.

### *Adding/Dropping Members*

HPS will bill a full month's contribution for members terminating during the month. Since any terminated employee is covered through the end of the month in which they terminate, no adjustments/refunds will be made as a result of a termination.

Your group will also be charged a full month's premium for all additions effective as of the 15<sup>th</sup> of the month. A half-month's premium will be charged for members added between the 16<sup>th</sup> and the 29<sup>th</sup> of the month. Members added on the 30<sup>th</sup> or 31<sup>st</sup> of the month will be added at no extra cost.

You must notify HPS promptly of any changes in your group membership. Retroactive credits will only be given for a two-month period following termination. HPS will not go back more than two months when issuing credits for termination.

HPS offers auto draft payment for ease and convenience in paying your monthly premium. Please refer to the Form Section for the form to sign up for auto draft or you may print one from the HPS website at [www.aahps.com](http://www.aahps.com).

## VI. Other Services

### *COBRA Administration*

Health Plan Select has partnered with a third party COBRA Administration Company to assist you with the challenging demands of COBRA Administration. We understand the overwhelming tasks involved with the day-to-day administration of this federal mandate and we are pleased to be able to provide this benefit to you as part of our overall service to your company. We know that COBRA is complex, and non-compliance can be costly. Fines of hundreds of dollars per employee can be assessed for every day that your organization is not in compliance with the rules and we want to make sure your organization is not at risk.

Automatic Data Processing (ADP) is one of the largest providers of computerized transaction processing and information-based business solutions — including Web-based solutions.

#### **ADP COBRA Services Frees Your Resources By:**

- Setting up your records on our proprietary system with electronic document archival and secure COBRA documentation
- Distributing notifications, correspondence, election packets, and COBRA termination notices as required by law
- Processing election forms and carefully tracking all key dates to ensure accurate and timely responses to COBRA administrative requirements
- Viewing health plan information, rates, and payment information
- Maintaining qualifying events and HIPAA loss-of-coverage data on-line
- Downloading your qualifying event data, HIPAA loss of coverage data and notifications
- Accepting and processing COBRA notification data via Electronic Data Transfer (EDT) file format
- Mailing the appropriate COBRA election package, HIPAA Certificate of Creditable Coverage, or the COBRA rights notification forms when files are received
- Keeping you informed with regularly-scheduled, extensive status reports
- Providing HIPAA Certificates of Creditable Coverage (optional)
- Mailing the appropriate COBRA election package, HIPAA Certificate of Creditable Coverage, or the initial COBRA rights notification forms when files are received

If you are an employer with more than 20 full-time employees and are interested in getting out from under the tremendous strain of COBRA administration, please contact the Sales Department for more information on ADP COBRA Administration.

### *Edgepark® Medical Supplies*

Health Plan Select is committed to providing quality care and services to all our members. We are especially committed to those members needing diabetic supplies and services to help manage this very serious disease. In an arrangement to provide diabetic members with the needed daily supplies, we contracted with Edgepark® to be the mail order supplier of diabetic supplies such as monitors, lancets, and test strips. These items are shipped directly to the member's home and are covered with no out-of-pocket expense to the member.

Edgepark® is also available to supply other medical supplies as needed such as TENS units, ostomy and wound care supplies. Please refer to the brochure in the forms section of this manual for additional information on Edgepark® or call 1-800-321-0591.

### *Health Management Corporation*

Health Management Corporation is the disease management company for HPS. We feel it is vital that our members have an avenue where they are able to seek information outside the normal channels to assist them in helping manage their chronic medical conditions. Health Management Corporation offers two (2) avenues for our members:

#### **Health Returns Care Management**

This program is a free, voluntary program to help your employees and or their dependents better manage chronic health conditions. The program offers care management of diabetes, coronary artery disease (CAD), and congestive heart failure (CHF).

#### **Health Returns 24-Hour Nurse Line**

This is a toll-free 24/7 service to answer questions about any medical condition. If you are traveling out of town and a child becomes ill, you can contact the Nurse Line to assist you in making an informed health care decision. The nurse line is staffed with registered nurses that provide you with one-on-one confidential counseling. The nurse line representatives work with HPS to provide information on members directed to the ER, if needed, so payment of the claim is not at issue.

For more information on these programs offered by Health Management Corporation please refer to the forms section of this manual for an information brochure.

## VII. Frequently Asked Questions

### *Coverage/Benefits*

**1. Will your plan send out detailed benefit information to employees?**

Yes, HPS provides a comprehensive benefits summary for each plan which describes coverage provisions to every subscriber. In addition, an Evidence of Coverage is provided to every new enrollee within the group. Additional information is provided if the group enrolls in pharmacy and/or dental coverage. These documents are also available on our website for members to review.

**2. When does coverage begin?**

Initial enrollees and eligible dependents are covered on the first day of the month following the employer group's waiting period.

**3. When traveling, can my employees receive coverage out-of-area?**

Employees and their dependents are covered anywhere in the world for emergency services. All claims must be translated into English and any charges converted to U.S. dollars.

### *Products*

**1. What products and services do you offer?**

We offer a wide array of medical and dental insurance products and services for employer groups. A complete list of products and services can be found on our web site at [www.aahps.com](http://www.aahps.com).

### *Pharmacy*

**1. Does HPS offer prescription drug coverage?**

Yes. HPS offers a variety of prescription drug plans. The benefit options include those plans with member copayments only for medications as well as those plans that pay all generics with a copayment only, while brand medications require a deductible be met before a percentage of the drug cost is paid by the plan.

HPS also offers an option for members to purchase their maintenance medications through a mail order pharmacy. Maintenance medications are those drugs that a member takes on a daily basis to control diseases such as hypertension, diabetes, high cholesterol, etc.

## *Notification of Changes*

**1. Who must be notified of a change of address or other administrative change for the group?**

HPS's Sales Department at (706) 549-0549, ext. 6350.

**2. How do I change the waiting period on our group policy?**

Send a written request for the change to your HPS Account Representative.

**3. What is the maximum waiting period a group can impose?**

Six months

## *Disabled Employees*

**1. I have an employee out on disability. How long am I required to keep them on the group health insurance policy?**

Continuation of a disabled employee's coverage is dependent upon your company's internal policies.

## *Primary Care Physician*

**1. What is a Primary Care Physician?**

A Primary Care Physician (PCP) is the doctor your employee must choose to give and/or arrange all medical care. The PCP is the medical case manager for your employee.

**2. Which type of doctors should my employee choose as a PCP?**

Family Practice doctors treat patients of all ages. Internal Medicine doctors generally treat patients over the age of 16. Pediatricians will treat children generally from birth to 18 years of age.

**3. Where do I find a list of Health Plan Selects PCPs?**

The PCPs are listed in the directory that is included in the enrollment kit and it is also available on our website at [www.aahps.com](http://www.aahps.com).

**4. What should my employee consider before choosing a PCP?**

Choosing a PCP is a personal decision. Before you decide, your employees may want to consider the following:

- Is the doctor's office near their home or work?
- Do the office hours meet their needs?
- Have they heard about the doctor from family or friends?

**5. Can my employees continue to see the doctor they were using before becoming a Health Plan Select member?**

If their doctor is a primary care physician and is listed in our Provider Directory the answer is YES. We suggest they contact their physician to update any prior insurance information and provide their updated Health Plan Select information.

For other questions related to specialists or providers outside the HPS network, please contact Member Services for direction.

**6. Does everyone in the family have to use the same PCP?**

No. Each family member may choose their own PCP.

**7. Will my employees need to schedule an appointment with their PCP after enrollment if they are a new patient?**

Yes, employees need to schedule an appointment to meet the PCP and go over their medical history. It is important to establish the doctor/patient relationship as soon as possible.

**8. Can a PCP be changed?**

Yes. Members may change their PCP twice a year. The change will be effective the first day of the month following receipt of the request. A new ID card will be issued showing the change.

Please contact Member Services or submit a change form to update the PCP.

**9. What if an employee needs to see a specialist?**

The PCP will arrange all of the employee's care. If the PCP feels a visit to a specialist is needed, they will refer the employee to an in-network specialist. HPS does not need to be notified of a referral by the PCP to an in-network specialist. An in-network specialist is defined as those providers within our service area that have signed contracts with HPS to provide specialty services to covered members. A listing of these providers can be found on our web site at [www.aahps.com](http://www.aahps.com).

**10. Are there any exceptions to the rule that HPS does not need to be notified of a referral by a PCP to see an in-network specialist?**

Yes. A referral is required for the following *in-network specialists*:

Pain Management Providers

Rehabilitation Services

Home Health Services

Physical, Speech and Occupational Therapy

Durable Medical Equipment (DME) Providers

*(Not an all-inclusive list. Call Member Services for any additional questions.)*

**11. What if care is needed from a certain type of specialist not available in the Health Plan Select network?**

**This requires a written referral from the PCP to HPS AND Prior-Authorization by HPS.** There may be times when a certain type of doctor is not available in the Health Plan Select network. In those situations Health Plan Select and its Medical Directors will authorize treatment by an out-of-network specialist. When approved, benefits will be paid as if the doctor was in-network.

## *Emergency Care*

**1. What if my employee has an emergency?**

An emergency is defined as a medical condition of a recent onset and sufficient severity, including but not limited to, severe pain that would lead a prudent layperson, possessing an average knowledge of medicine and health, to believe that his or her condition, sickness, or injury is of such a nature that failure to obtain immediate medical care could result in (1) placing the patient's health in serious jeopardy, or (2) serious impairment to bodily functions, or (3) serious dysfunction of any bodily organ or part, or (4) with respect to a pregnant Member who is having contractions, that there is inadequate time to safely transfer her prior to delivery or that such transfer may pose a threat to the health or safety of the Member or her unborn child.

**How will this be paid?** For treatment of an illness or injury determined to be an emergency, the member will be responsible for the applicable emergency room co-payment listed on their benefit summary.

**2. What if my employee has an urgent problem, but it doesn't meet the definition of emergency?**

During regular office hours, employees should call their PCP. If necessary, an appointment will be made for that day or the following business day. The PCP may send the employee to an urgent care center or the emergency room.

HPS has three (3) urgent care centers with extended office hours. The facilities are called *Regional First Care* and they are located:

**Jefferson**  
528 Panther Drive  
Jefferson, GA 30549  
Phone: 706.387.5555

**North Athens**  
485 Highway 29 North

Athens, GA 30601  
Phone: 706.353.6000

**Watkinsville**  
1960 Experiment Station  
Watkinsville, GA 30677  
Phone: 706.769.0000

### **Regular Business Hours**

Monday - Friday: 8 am - 8 pm Saturday & Sunday: 10 am - 6 pm

A referral is NOT required to visit the Urgent Care facilities.

### **3. What if my employee is out of town and needs care?**

If your employees are out of town and have a life-threatening or serious emergency, they should call 911 or go to the nearest hospital emergency room for treatment. Employees are also encouraged to utilize our 24-hour nurse line at 1-800-337-4770. Registered nurses are on call 24/7 to provide guidance to HPS members on how to handle emergency as well urgent medical situations. If members are directed to the ER by the nurse line, HPS is notified the next business day and an authorization is entered in the claims system to pay any related expenses.

## *Dependent Eligibility*

### **1. Up to what age are dependent children covered by the Health Plan Select plan?**

Health Plan Select covers dependent children up to the age of 19. If they are a fulltime (minimum 12 hours) college student, they may be covered up to and including the age of 26. Verification of full-time student status is needed from the institution to extend benefits beyond age 19. Please see information in Section II – *Dependent Eligibility* for more information.

### **2. What if my employee has a child away at college, can they be covered on Health Plan Select?**

If your employee is enrolled in the HMO plan their child is only covered for emergency care if they are outside the HPS Service Area. Follow up care for the injury will need to be obtained from a provider in the HPS network.

If your employee is enrolled in the POS plan, the child can receive out-of-network benefits as well as emergency treatment. Follow up care can be obtained out of network, subject the out-of-network benefits (deductible and co-insurance).

### **3. If my employee is divorced and responsible for the medical insurance for their dependent children, will the children be covered if they live out of the service area?**

Employees who are court ordered to cover their children who live out of the service area may do so by enrolling in the Point of Service Plan. The HMO plan will only provide benefits for medical emergencies.

**4. Can my employee continue to cover their spouse on their medical coverage if court ordered to do so following a divorce?**

Ex-spouses are not eligible for coverage under an employee's health plan through HPS. Groups with 20 or more employees can be covered under the COBRA continuation of coverage provision and previously covered spouses are eligible for up to 36 months of additional coverage following a divorce.

For groups with less than 20 employees divorced spouses will be eligible for Georgia Continuation of Coverage for up to an additional three (3) months of coverage.