2015 Eligibility &Enrollment Provisions

State Health Benefit Plan

Effective Date January 1, 2015

Introduction

The State Health Benefit Plan "SHBP or "the Plan" consists of three plans established by Georgia law: a plan for State employees, a plan for public school teachers, and a plan for public school employees other than teachers. The SHBP is self-insured for all Plan options, including Blue Cross Blue Shield of Georgia (BCBSGa) Health Reimbursement Arrangement (HRA) and Health Maintenance Organization (HMO); and UnitedHealthcare HMO and High Deductible Health Plan (HDHP); Kaiser Permanente HMO, which is fully insured and governed by certain Georgia laws, the regulations of the Department of Community Health (DCH) Board, Chapter 111-4- 1 Health Benefit Plan, and resolutions of the Board of Community Health that establish required contributions that must be paid to the SHBP. If there are discrepancies between the information in these Eligibility and Enrollment Provisions and DCH Board regulations or the laws of the State of Georgia, or the Board resolutions setting required contributions, those regulations, laws and resolutions will govern at all times.

This booklet is notice to all Covered Persons of the Plan's eligibility requirements for services provided on or after January 1, 2015, unless otherwise noted. Any and all statements to Covered Persons or to providers about eligibility, payment or levels of payment that were made before January 1, 2015 are canceled if they conflict in any way with the provisions described in these Eligibility and Enrollment Provisions.

The Department of Community Health, SHBP Division, is the Plan Administrator, and reserves the right to act as sole interpreter of all the terms and conditions of the Plan, except where expressly delegated to the following Administrators. The Plan Administrator has delegated full responsibility for claims administration under the various plan components, that is, well-being incentives and programs, medical benefits and pharmacy benefits, to the following Claims Administrators:

Blue Cross Blue Shield of Georgia ("BCBSGa"),
UnitedHealthcare of Georgia, and
Kaiser Permanente Georgia ("KP")
Medical Claims Administrators

Healthways, Inc., Wellness Administrator

Express Scripts, Inc. ("ESI"), Pharmacy Claims Administrator

Please refer Contact/Resource Information page of this Eligibility and Enrollment Provisions for more detail on the appropriate department names and telephone numbers that you will need for questions, customer service, claims submission and appeals.

The Administrators for the various plan components process and pay claims in accordance with the terms of the Plan Documents, which include this Eligibility Document and the separate Summary Plan Descriptions (SPDs) guidelines that serve

as supplements to this Eligibility Document to more fully define eligible charges. The Claims Administrators have the discretion to interpret the terms of the their plan component when processing and paying claims and making final decisions with respect to claims that fall under their Plan Component. Plan benefits provided under each of the three Plan Components are described in their respective chapters of the 2015 SPDs. The chapters of the Eligibility Document apply to all Plan options unless otherwise noted.

The Department of Community Health reserves the right to modify the benefits, level of benefit coverage and eligibility/participation requirements for the Plan at any time, subject only to reasonable notification to Members. When such a change is made, it will apply as of the modification's effective date to any and all charges incurred by Members on that day and after, unless otherwise specified by the DCH.

How to Use this Document

We encourage you to read this Eligibility Document and the SPDs carefully, and make sure you understand the eligibility requirements and benefits available to you, the benefit limits, and your cost-sharing requirements. You should call the appropriate program Administrator if you have questions about the benefits and cost-sharing requirements. The SPDs are posted online at www.dch.georgia.gov/shbp under SHBP Plan Documents. Please be aware that neither your Physician nor your pharmacist has a copy of the SPDs, and neither is responsible for knowing or communicating your Benefits.

Information about Defined Terms

Because this Eligibility Document is a legal document, we want to give you information about the document that will help you understand it. Certain capitalized words have special meanings. A glossary of defined terms is included at the end of this document.

When we use the words "we," "us," and "our" in this chapter document, we are referring to the Department of Community Health, Division of SHBP. When we use the words "you" and "your," we are referring to people who are Covered Persons as the term is defined in the chapter glossary.

Fraud and Abuse

Please notify the appropriate program Administrator of any fraudulent activity regarding Plan members, providers, payment of benefits, etc. Please see Contact/Resources Information on pages 5 and 6 for telephone numbers to call to report fraud and abuse.

Your Contribution Requirements

All Members are required to make regular contributions (called premiums) in order to maintain coverage. All contributions by

active employees must be made through salary deductions. Contributions by former employees must be made through annuity deductions, if possible, or through direct payments. The Board of Community Health sets the contribution requirements by resolution.

Usually, the contribution requirements are set on an annual basis before Open Enrollment and the Retiree Option Change Period, but contributions may be changed by the Board at any time, subject to advance notice. It is the Member's responsibility to make sure that the contributions paid are appropriate for the plan option selected. The required contributions are posted on www.dch.georgia.gov/shbp. If you are actively employed, contact your benefits representative for information about the required contributions you are responsible for paying.

Membership Correspondence and Appeals for Eligibility and Enrollment

Member appeals regarding eligibility and enrollment issues should be initiated through SHBP Member Services by calling 1.800.610.1863.

SHBP
State Health Benefit Plan

STATE HEALTH BENEFIT PLAN (SHBP)
CONTACT / RESOURCES INFORMATION

	Member	Website
Medical Claims Administrator- Blue Cross Blue Shield of Georgia Member Services Hours: 8:00 a.m. – 8:00 p.m. ET Monday – Friday Fraud Hotline	1-855-641-4862 (TTY 711) 1-800-831-8998	www.bcbsga.com/shbp
Medical Claims Administrator- UnitedHealthcare **Member Services Hours: 8:00 a.m. – 8:00 p.m. ET** **Monday-Friday** **Fraud Hotline**	888-364-6352 866-242-7727	www.myuhc.com/shbp
Kaiser Permanente **Member Services: 24 hours a day/7 days a week** **Fraud Hotline**	855-512-5997 855-512-5997	www.my.kp.org/shbp
Wellness Program Administrator- Healthways Member Services Hours: 8:00 a.m. – 8:00 p.m. ET Monday – Friday Healthways Corporate Compliance	1-888-616-6411 1-866-225-0836	www.BeWellSHBP.com
Pharmacy Claims Administrator- Express Scripts Member Services Hours: 24 hours a day / 7 days a week Fraud Tip Hotline	1-877-841-5227 1-866-216-7096	Express-scripts.com/GeorgiaSHBP email: fraudtip@express-scripts.com
SHBP Member Services Hours: 8:30 a.m. – 5:00 p.m. ET Monday – Friday	1-800-610-1863	www.mySHBPga.adp.com
Additional Information		
Centers for Medicare & Medicaid (CMS) 24 hours a day / 7 days a week	1-800-633-4227 TTY 877-486-2048	www.medicare.gov

Section 1.1:

Eligibility for SHBP as an Active Employee; When Coverage as an Active Employee Begins and Ends

How to Enroll as a New Hire

To enroll, the Eligible Person has 31 days from date of hire to go online and make an election for coverage. If no election is made the system will default member to No Coverage. SHBP will not provide Benefits for health services received before the effective
e date of coverage.

How to Make an Election

To make your election electronically:

- **Go to the enrollment web portal www.mySHBPga.adp.com (available 24/7) and enter registration code SHBP-GA**
- **Set up your password and provide an email address**
- **Follow prompts until finished and you will have a confirmation number**

To make your election telephonically:

- **Call 1-800-610-1863 during the hours of operation: 8:30am ET to 5:00pm ET**
- **Read Terms and Conditions in your Decision Guide prior to making election**

Eligible

Complete eligibility rules are set forth in SHBP statutes and

The Plan Administrator

Who is Eligible for Coverage

Who	Description	Who Determines Eligibility
Person	regulations, and the rules in the statutes and regulations control if there is a conflict with this summary. Although currently operated as one plan, there are actually three plans that make up the SHBP: a plan for State employees described in O.C.G.A. §45-18-1, a plan for public school teachers described in O.C.G.A. §20-2-881, and a plan for public school service personnel other than teachers described in O.C.G.A. §20- 2-911. *Eligibility rules for the plan for State employees.* "Regular full-time" means you are scheduled to work at least 30 hours a week and you work at least 30 hours a week consistently. "Full-time" employee means you are classified by your employer as a full-time employee. "Part-time" employee means you are classified by your employer as a part-time employee. Not Eligible: individuals classified by the employer as temporary (expected to work less than nine months), seasonal workers, intermittent workers or independent contractors. In general, you are eligible to enroll yourself, spouse and your eligible dependents for coverage if you meet one of the descriptions below. • A regular full-time employee of a department, board, agency or commission, General Assembly, or community service board of the State of Georgia; • A part-time employee of the General Assembly who had coverage prior to January 1981 or an administrative or clerical employee of the General Assembly; • A full-time district attorney, assistant district attorney or a district attorney's investigator of the Superior Courts appointed pursuant to O.C.G.A. § 15-18-14;	determines who is eligible to enroll under the Plan. The Plan Administrator

Who is Eligible for Coverage

Who	Description	Who Determines Eligibility
	• A full-time secretary or law clerk employed by district attorneys and judges and employed under O.C.G.A. §§ 15-18-17 and 15-18-19; • A regular full-time employee who receives salary or wage payment from a county Board of Health or county Board of Family and Children Services; • A member of the General Assembly; • A regular full-time employee of a State authority that participates in the Employees' Retirement System and participates in the Plan by paying all required contributions to the Plan; • A regular full-time employee of an entity that offers the Plan to its employees pursuant to a current contract with the Department of Community Health; • In some cases, employees described above may continue SHBP coverage after resignation with 8 or more Years of Service or retirement with an annuity. See Section 1.2 for details. Employees who terminate employment with less than 8 Years of Service may be able to continue SHBP coverage through COBRA. See Section 1.4	determines who is eligible to enroll under the Plan.
	Eligibility rules for the plan for public school teachers. 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. Eligible teacher also means librarians and other personnel employed not less than 30 hours per week by regional and county libraries. An eligible teacher shall not include any independent contractor, emergency or temporary worker, or person employed by a charter school that has not elected to offer SHBP coverage, or that has revoked SHBP coverage. Eligible teachers must be	The Plan Administrator determines who is eligible to enroll under the Plan.

Who is Eligible for Coverage

Who	Description	Who Determines Eligibility
	employed not less than seventeen and a half (17 ½) hours per weeks, and are further defined as • A person employed in a professionally certificated capacity or position in the public school systems of Georgia; • A person compensated in a professionally certificated capacity or position in a charter school that has elected to offer SHBP coverage and has not revoked SHBP coverage; • A person employed in a professionally certificated capacity or position in the public vocational and technical schools operated by a local school system; • A person employed in a professionally certificated capacity or position in the Regional Educational Service Areas of Georgia; • A person employed in a professionally certificated capacity or position in the high school program of the Georgia Military College; In some cases, employees described above may continue SHBP coverage after resignation with 8 or more Years of Service or retirement with an annuity. See Section 1.2 for details. Employees who terminate employment with less than 8 Years of Service may be able to continue SHBP coverage through COBRA. See Section 1.4.	
	Eligibility rules for the plan for other public school employees. • Any person who is not eligible under the rules above for the plan for public school teachers, who is employed by a local school system that has not withdrawn from the plan for public	The Plan Administrator determines who is eligible to enroll under the Plan.

Who is Eligible for Coverage

Who	Description	Who Determines Eligibility
	school employees in accordance with requirements of the DCH, or who is employed by a charter school that has elected to offer SHBP coverage and has not revoked SHBP coverage, and who meets the following work requirements: • If you are eligible to participate in the Teachers Retirement System or its local equivalent, you must work at least 60% of a standard schedule for the position, as determined by the employer, but not less than 20 hours a week, and you may not be classified by your employer as an independent contractor or emergency or temporary worker. • If you are eligible for the Public School Employees' Retirement System, you must work at least 60% of the standard schedule for your position, but not less than 15 hours a week, and not be employed as an independent contractor or on an emergency or temporary basis. • If you are an employee of a charter school who is not	

Who is Eligible for Coverage

Who	Description	Who Determines Eligibility
	working in a certificated position or capacity, you must work at least half-time, and not be employed as an independent contractor or on an emergency or temporary basis. • In some cases, employees described above may continue SHBP coverage after resignation with 8 or more Years of Service or retirement with an annuity. See Section 1.2 for details. Employees who terminate employment with less than 8 Years of Service may be able to continue SHBP coverage through COBRA. See Section 1.4 for details.	
Dependent Eligible Dependents are:	**Your legally married spouse, as defined by Georgia law.** (1) **Natural or legally adopted children or Stepchildren, under age 26. Natural Child** – child for which the natural guardian has not relinquished all guardianship rights through a judicial decree. Eligibility begins at birth and ends at the end of the month in which the child reaches age 26. **Adopted Child** – eligibility begins on the date of legal placement for adoption. **Stepchild** – eligibility begins on the date of marriage to the natural parent. Eligibility ends at the end of the month in which the child reaches age 26 or at the end of the month in which he or she loses status as a stepchild of the enrolled member, whichever date is earlier. (2) **Other children under 26**. A dependent child for whom the enrolled member is the legal guardian. Eligibility begins on the date legal guardianship is established and ends at the end of the month in which the child reaches age 26 or at the end of the month in which the legal guardianship terminates, whichever is	The Plan Administrator determines who is eligible to enroll under the Plan.

Who is Eligible for Coverage

Who	Description	Who Determines Eligibility
	earlier. (3) **Your natural children, legally adopted children or stepchildren 26 or older from categories 1 and 2** above who are physically or mentally disabled prior to age 26, and are primarily dependent on the Enrolled Member for support and maintenance.	
For a Covered Dependent age 26 & older and disabled before age 26	*You must:* • File a written request for continuation of coverage before or on the dependent's 26th birthday and, when requested by the Plan, re-certify your dependent(s). If you fail to re-certify your dependent(s), your dependent will no longer be eligible to be covered under the Plan.	The Plan Administrator determines who is eligible to enroll under the Plan.
To enroll a disabled child as a new dependent (child must be disabled prior to age 26)	**You must:** • Make request within 31 days of your hire date or qualifying event date or add during Open Enrollment period; and • Provide medical documentation that must be approved by the Plan.	The Plan Administrator determines who is eligible to enroll under the Plan.
Qualified Medical Child Support Order (QMCSO)	SHBP will honor a QMCSO for eligible dependents. A QMCSO creates, recognizes, or assigns the right for a dependent to receive benefits under a health plan. See Glossary and Qualifying Events for more information regarding what coverage changes are allowed	The Plan Administrator determines who is eligible to enroll under the Plan.

SHBP
State Health Benefit Plan

Who is Eligible for Coverage

Who	Description	Who Determines Eligibility
Who is Not Eligible for Dependent Coverage	The most common examples of persons not eligible for SHBP dependent coverage include: • Your former spouse • Your fiancé • Your parents • Children age 26 or older who do not qualify as disabled dependents • Grandchildren who cannot be considered eligible dependents • Anyone living in your home that is not related by marriage or birth, unless otherwise noted.	The Plan Administrator determines who is eligible to enroll under the Plan.

NOTE: If you misrepresent eligibility information when applying for coverage, during a change in coverage or when filing for benefits, or by paying for coverage on behalf of someone who is not eligible, adverse action may be taken against you by DCH or applicable enforcement agencies. Adverse actions include, but are not limited to: terminating your coverage, collection actions for all payments improperly made as a result of the misrepresentation, and criminal prosecution.

When to Enroll and When Coverage Begins

You must enroll to have SHBP coverage
To enroll, go to your personnel/payroll office for instruction, or:

- Go online at: www.mySHBPga.adp.com
- Follow steps on the Enrollment time line
- Choose a coverage option
- Answer the Tobacco question
- Choose a coverage tier (you only, you + spouse, etc.)
- If you wish to cover dependents check the appropriate box

Please refer to “Who is Eligible for Coverage” for more information. Once you make your coverage election, changes are not allowed outside the Open Enrollment Period, unless you have a qualified change in status under Section 125 of the Internal Revenue Code, which restricts changes to coverage in the SHBP outside the annual Open Enrollment Period.

Retirees cannot add dependents during the Annual Retiree Option Change Period. A retiree must make the election to add a dependent upon an eligible qualifying event.

- Provide the name(s) of eligible dependents you want to enroll and cover

You must provide documentation to verify dependents' eligibility within 45 days of coverage or your election will be canceled. Once you have elected to cover a dependent, the coverage will be granted and premiums charged. You have 45 days from date of election to fax the required documentation. When sending supporting documentation, the barcoded instructional email and/or letter must be attached. If you do not provide the documentation necessary to verify eligibility by the 45 day deadline, you will be charged premiums for the tier you selected and coverage will cease for the dependent(s) without refund. Enrollment authorizes periodic payroll deductions for premiums. If you list dependent(s), you must elect a coverage tier that covers the dependent(s) by relationship to you.

SHBP
State Health Benefit Plan

Contributions Surcharge Policy

Tobacco Surcharge:

A tobacco surcharge of $80 is added if you answer yes to the tobacco surcharge questions during your Initial Enrollment, Open Enrollment, the Retiree Option Change Period, or a Qualifying event. The tobacco surcharge may be removed by following the tobacco surcharge removal procedures found on the Department of Community Health website, www.dch.georgia.gov/shbp.

You are required to pay the tobacco surcharge for all months in which you or any of your enrolled family members use tobacco. Therefore, it is your responsibility to notify DCH, SHBP Division immediately if your answers to the tobacco surcharge questions change during the year. If you received a waiver of the tobacco surcharge based on your answers and you fail to notify DCH, SHBP Division that you or a member of your enrolled family members begins using tobacco, this may be viewed as an intentional misrepresentation.

NOTE: The Tobacco Surcharge does not apply to options that include Tricare Supplements, Medicare Advantage (MA) or COBRA members paying 100 percent of the premiums for their health coverage. However, you still must answer the tobacco surcharge questions on website to proceed with enrollment.

Intentional misrepresentation in response to the tobacco surcharge questions or failure to notify DCH, SHBP Division of changes to your responses to the surcharge questions will have significant consequences. Active employees will lose SHBP coverage for 12 months beginning on the date that your false response or failure to notify is discovered. Retirees who intentionally misrepresent the response to the tobacco surcharge questions or fail to notify DCH, SHBP Division of changes to their responses will permanently lose their SHBP health insurance.

SHBP
State Health Benefit Plan

Enrollment Periods

Who	Enrollment Action	Enrollment Information
Initial Enrollment Period The Initial Enrollment Period is the first period of time when Eligible Persons can enroll.	Eligible Employees may enroll themselves and their Dependents.	Enrollment must be completed within 31 day of your date of hire.
Open Enrollment Period	Open Enrollment occurs every fall for the following plan year. Eligible Persons may enroll themselves and their Dependents. A Dependent removed during the Open Enrollment period is not eligible for COBRA.	The Plan Administrator determines the Open Enrollment Period. Coverage begins on January 1st of the following Plan year.
A current employee	• Make coverage changes during Open Enrollment • Make coverage changes within 31 days of a qualified event (45 days for newly eligible dependent child) **Please refer to Enrolling a Newly Eligible Dependent for further details**	The upcoming January 1st

Who	Enrollment Action	Enrollment Information
A newly hired employee	• Enroll in a plan option (if eligible) within 31 days of your hire date	• Coverage is effective the first of the month after a full calendar month of employment
A rehire with the same employer or another employer that offers SHBP coverage	• A rehire with a break in coverage of 30 days or less must continue with the same plan option and tier. A termination and reemployment outside the 30 day period, is treated as a new hire.	• First of the month following a salary deduction for Plan coverage

SHBP
State Health Benefit Plan

Enrolling a Newly Eligible Dependent

If you have a new dependent due to marriage, birth, adoption or guardianship, you may enroll your dependent(s).The DCH, SHBP Division must collect the Social Security Number (SSN) for each dependent age two or older. Do not wait for verification documentation to enroll dependent(s). The SSN is not required for a dependent child until age two. However, failure to provide the SSN when the child reaches age two will result in termination of coverage for the dependent child. Provide the SSN for a dependent child as soon as it is available.

The next section describes what you need to do if you wish to add a newly eligible dependent.

	To Enroll a Newly Eligible Dependent and…	You Will Need To:
New Eligible Dependent	• If your dependent is currently eligible for the tier you are enrolled in.	• You must add within 31 days of the marriage or 90 days for birth/adoption.
	• If your current tier does not cover dependents	
	• If you have a court order that requires you to enroll dependent child(ren)	• Submit the order to SBHP for approval. • If DCH, SHBP Division approves the court order as a QMCSO, your coverage tier will be changed if needed to enroll the dependent child (ren). • You must change tier and pay appropriate premium if current tier does not.

Identification Cards

After you enroll, you will receive an identification (ID) card for yourself and each eligible dependent, if applicable. The ID card must be presented when care is received.

When Coverage Begins

When your coverage starts depends on when you enroll and when you make requests that affect your coverage.

	IF YOU ENROLL:	YOUR COVERAGE BEGINS:
For Transferring Employees	If you are transferring between employers that offer SHBP coverage: • Contact your new employer to coordinate continuous coverage • You must continue the same coverage and tier, unless you had a break in coverage of 31 days or more.	• Coverage is continuous between transferring employers, as long as a break in employment is 30 days or less. If there is a break in employment with employers that offer SHBP coverage that is longer than 30 days, coverage begins on the first day of the month following one full month of employment, if re-enrollment occurs.
For You	• During an Open Enrollment Period • As a new employee. • When you are reinstated or return to work from an unpaid leave of absence that occurred during an Open Enrollment period. • When you have a qualifying event.	• On January 1st of the new Plan year • One the first day of the month following one full calendar month of employment • On the first day of the month following the return or, if a judicial reinstatement, on the day specified in the settlement agreement

For Your Dependents

As a new employee, dependent coverage begins when your coverage begins, as long as proper dependent verification is submitted by the deadline. If you add dependents within 31 days 90days for newly eligible dependent child) of a qualifying event, coverage takes effect as described in this Section under the heading *Adding Dependents* and the chart on the next page. The Centers for Medicare & Medicaid Services (CMS) regulations now require the DCH, SHBP Division to collect the Social Security Number (SSN) for each covered dependent. You should provide DCH, SHBP Division the SSN for your dependent child as soon as it is available, but no later than age two.

NOTE: Dependent verification documentation must be received within 45 days of election or dependent coverage election will be cancelled and dependent will be removed and they will not be eligible for coverage. Acceptable verification documentation: **Spouse** – Copy of certified marriage certificate or most recent jointly filed Federal Tax return which includes legible signatures for both member and spouse. **Natural Child** – Copy of certified birth certificate or for newborns a letter of confirmation of birth that include parent name. **Step-Child** – Copy of certified birth certificate that include spouse name as one of the parents and a copy of certified marriage certificate of member to spouse

Adding Dependents

When you add a dependent, the Plan will request dependent verification documentation. You must submit the documentation requested by the Plan in order to continuously cover the dependent. CMS regulations now require the DCH, SHBP Division to capture the Social Security Number (SSN) for each covered dependent. If documentation and the SSN (except for newborn) are received within 45 days of election, the plan will cover the dependent as long as the correct tier and premium is paid. The SSN is not required for a dependent child until age two. However, failure to provide the SSN when the child reaches age two will result in termination of coverage for the dependent child. Provide the SSN for a dependent child as soon as it is available. If you elect to cover dependents and do not provide documentation necessary to verify eligibility by deadline, your dependents will cease without refund.

SHBP
State Health Benefit Plan

If You Add This Dependent:	Provide This Documentation:	Coverage Takes Effect:
A Baby Within 90 days after the qualifying event	• Copy of certified birth certificate or a birth card issued by the hospital listing parents by name **NOTE:** A birth document that does not include the Eligible Person's name as a parent is not acceptable.	• On the day your child was born, if the proper premiums are paid, starting with premiums for the birth month.
An Adopted Child Within 90 days after the qualifying event	A certified copy of court documents establishing adoption and stating the date of adoption or if adoption is not finalized, certified or notarized legal documents establishing the date of placement for adoption	• On the date of legal placement and physical custody
Disabled Child Within 31 days of the child's becoming disabled and the disabled dependent child: • Is unable to self-support themselves due to mental or physical disability. • Depends mainly on the Member for support. • Was disabled prior to age 26. • Meets SHBP disability requirements	• Copy of certified birth certificate or a certification letter of birth card issued by the hospital listing parents by name. • Social Security Number • Proof of the child's disability and dependency requirements furnished to DCH, SHBP Division within 31 days of enrollment in the Plan; or date coverage would otherwise have ended because the disabled dependent child reached age 26.	• On the first of the month following approval of the medical documentation submitted to DCH, SHBP Division • When you have changed tiers to cover the disabled dependent child
DCH, SHBP Division may periodically ask you for proof that the Member's child continues to meet these conditions of disability and dependency		
	• Copy of marriage certificate and	• On the day of the event

If You Add This Dependent:	Provide This Documentation:	Coverage Takes Effect:
A New Spouse Within 31 days after the qualifying event	Social Security Number	
Stepchild (ren) Within 31 days prior to or after the qualifying event 90 days if a newly eligible dependent child) **Note**: A birth document that does not include the parent's name is not acceptable.	• Copy of birth certificate showing your spouse is the natural parent; and copy of certified marriage license showing the natural parent is your spouse; or copy of your most recent Federal Tax Return (filed jointly with spouse) including legible signatures for you and your spouse with financial information blacked out and Social Security Number.	• On the first day of the month following the qualifying event or your change to the appropriate coverage tier
A child due to a Qualified Medical Child Support Order (QMCSO)	• Social Security Number • Copy of the court order listing children that you must cover	• On the first day of the month following the request, if DCH, SHBP Division approves the court order as a QMCSO.

SHBP
State Health Benefit Plan

Qualifying Events that Allow Coverage Changes for Active Employee Members

If you are an actively employed Member and have one of the following qualifying events during the year, you may be able to make a coverage change that is consistent with the qualifying event. If you are a retiree, refer to the retiree section, once posted, for permitted coverage changes. CMS regulations now require the DCH, SHBP Division to capture the Social Security Number (SSN) for each covered dependent. The SSN is not required for a dependent child until age two. However, failure to provide the SSN by the time the child reaches age two will result in termination of coverage for the dependent child. Provide the SSN for a dependent child as soon as it is available.

If you or an enrolled dependent(s) experience a qualifying event which results in coverage under a new contract, the entire deductible and out-of-pocket maximum under the new contract has to be met. All HRA, My Incentive Account (MIA), or Health Incentive Account (HIA) balances (if applicable), deductibles and out-of-pocket maximums will remain with the prior contract. Pro-rated HRA credits will be applied to the new contract based on the elected coverage tier and months remaining in the current plan year. Deductibles and out-of-pocket maximums are not pro-rated.

The following chart shows qualifying events and the corresponding changes that active Members can make.

Events:	Provide This Documentation:	Within 90 days after Qualifying Event you May/Must
Birth **NOTE**: The Social Security Number is not required until age two. Failure to provide the Social Security Number at age two will result in termination of coverage for the dependent child.	• Copy of certified birth certificate or birth card issued by the hospital listing parents by name.	• Enroll in coverage • Change coverage tier to include child(ren) • Enroll eligible dependents • Change to any available option for you + child(ren) or you + family

SHBP State Health Benefit Plan

Events:	Provide This Documentation:	Within 45 days after QE you
Marriage **NOTE:** You have 90 days after a qualifying event to enroll a newly eligible dependent child.	• Certified copy of marriage certificate required • Spouse's Social Security Number	• Enroll in coverage • Change coverage tier to include spouse. • Discontinue coverage; letter from other plan documenting you and your covered dependents are enrolled in spouse's plan. The letter should include the names of all covered dependents.
Adoption (90 days if adopted child is a newly eligible dependent child), legal guardianship	• **Adoption:** Adoption certificate or court order placing child in home • **Legal Guardianship:** Certified copy of court documents establishing adoption and stating the date of adoption, or, if adoption is not finalized, certified or notarized legal documents establishing the date of placement for adoption. If certified copy of the birth certificate is not available, other proof of the child's date of birth is required	• Enroll in coverage • Change coverage tier to include child(ren) • Enroll eligible dependents • Change to any available option for you + child(ren) or you + family

SHBP State Health Benefit Plan

Divorce

Adding coverage for yourself

- Copy of divorce decree and loss of coverage documentation required
- Furnish Social Security Number for each dependent you wish to cover

Removing a former spouse from coverage

- Copy of divorce decree

- Enroll in coverage, if losing coverage through spouse's plan
- Must remove spouse from coverage
- Must remove step-children from coverage
- Change coverage tier
- Enroll eligible dependent

If a court order approved by DCH, SHBP Division as a QMCSO requires:	You can:
You to provide coverage for your natural child(ren)	Enroll or change coverage tier – there is no time limit for this change; documentation of the court order is required
Your former spouse must provide coverage for each of your enrolled natural child(ren)	Change coverage tier; documentation of the court order and the other coverage is required
Spouse to provide coverage for his/her natural children Furnish Social Security Number and dependent verification documentation for each dependent you wish to cover	Enroll or change coverage tier – no time limit for this change; documentation of the court order requiring coverage is required

You or your spouse lose coverage through other employment	• Letter from other employer documenting loss of coverage and reason for loss is required • Furnish Social Security Number and dependent verification for each dependent you wish to cover	• Enroll eligible dependent(s) • Enroll In Coverage • Change coverage tier •
You, your spouse, or enrolled dependent are covered under a qualified health plan and you lose eligibility, such as through other employment, Medicaid*, State Children's Health Insurance Program (SCHIP) or Medicare	• Furnish Social Security Number and dependent verification for each dependent you wish to cover • Letter from other employer, Medicaid, or Medicare documenting date and reason for loss or discontinuation required	• Change coverage tier • Enroll eligible dependent(s) • Enroll In Coverage **NOTE**: For loss of Medicaid or SCHIP coverage, you have 60 days for actions above
Loss of last dependent(s) that impacts your Tier	• Provide documentation stating the reason and date eligibility was lost unless the reason for loss of coverage is because of reaching age 26	• Change coverage tier

Your former spouse loses other qualified coverage, resulting in loss of your dependent child(ren)'s coverage under former spouse's plan	• Furnish Social Security Number and dependent verification for each dependent you wish to cover • Letter from other plan documenting name(s), of everyone who lost coverage, date, reason, and when coverage was lost	• Enroll eligible dependent(s) eligible dependent(s) • Increase coverage tier
Covered Dependent Loses Eligibility	• Provide documentation stating the reason and date eligibility was lost unless the reason for loss of coverage is because of reaching age 26 • No documentation required to change coverage tier for last **child who turns 26.**	• Change coverage tier to remove ineligible spouse and/or dependent(s) •
Gain of coverage due to other employer's open enrollment **NOTE**: Plan year can be the same, but Open Enrollment dates must be different	• Letter from other employer documenting name(s) of everyone who gained coverage, date, reason, and when coverage was gained	• Change coverage tier to remove spouse and/or dependent(s) • Discontinue coverage
Loss of coverage due to other employer's open enrollment **NOTE**: Plan year can be the same, but Open Enrollment dates must be different	• Furnish Social Security Number for each dependent you wish to cover • Letter from other employer documenting name(s) of everyone who lost coverage, date, reason, and when coverage was lost	• Enroll eligible dependent(s) • Enroll In Coverage • Change coverage tier

You or your spouse acquire new coverage under spouse's employer's plan	• Letter from other plan documenting your effective date of coverage and names of covered dependents	• Change tier to cover you only • Discontinue coverage – you must document that all members removed from the SHBP coverage are covered under the other employer's plan
Your spouse or your only enrolled dependent's employment status changes, resulting in a gain of coverage under a qualified plan other than from SHBP	• Letter from other employer documenting coverage enrollment required, and • Everyone removed from coverage under the SHBP must be enrolled in the plan. This includes coverage acquired due to the other employer's open enrollment.	• Change coverage tier to remove spouse and/or dependent(s) • Discontinue coverage
You or your spouse is activated into military services	• Furnish Social Security Number and dependent verification for each dependent you wish to cover • Copy of orders required	• Enroll in coverage • Change coverage tier • Discontinue coverage

SHBP State Health Benefit Plan

You retire and immediately qualify for a retirement annuity with a State Retirement System other than ERS, TRS, or PSERS	• You must complete and submit the Retiree/Surviving Spouse form no later than 60 days after leaving active employment. Automatic deductions for health coverage should start when the retiree receives his/her initial retirement check. It is your responsibility to verify that the health insurance deduction was taken from your initial retirement check.	• Change tier to cover you only • Change Option • Discontinue Coverage

NOTE: If your retirement system is ERS, TRS or PSERS you will automatically be enrolled in same option and tier as a retiree. You will receive a letter from SHBP advising you that the change was made and stating you have 31 days if you wish to make a change in coverage. However, if you and/or a covered dependent are enrolled in a minimum of Medicare Part B, coverage will roll over to the Medicare Advantage (MA) Standard Option. The DCH, SHBP Division must have received and processed your Medicare information in order for the rollover to occur. You also must have a street address, as CMS will not approve enrollment in a MA option with a P.O. Box as your address.

You retire and immediately qualify for a retirement annuity under the Georgia ERS, TRS, or PSERS retirement system	Coverage will automatically roll to the same option and tier you had as an active employee. Employees or covered dependents with Medicare Part B coverage and are age 65 or older will roll to the Medicare Advantage Standard option. Automatic deductions for health coverage only start when the Retiree receives his/her initial retirement check from ERS, TRS or PSERS. It is your responsibility to verify that the health insurance deduction was taken from your initial retirement check.	• Change tier to cover you only • Change Option • Discontinue Coverage

Spouse's Loss of Eligibility for Health Insurance due to Retirement NOTE: Retirement without loss of eligibility for health insurance, discontinuation of coverage, reduction of benefits, or a change in premiums ARE NOT qualifying events.	• Letter from other employer documenting loss of coverage, date coverage ended and reason for loss is required.	• Change coverage tier • Enroll eligible dependents • Discontinue coverage • Lower coverage •
Retiree Returning to Work as an Active Employee	• If you return to work as an active employee with an employing entity under the Plan, either immediately after you retire or at a later date, your retirement annuity may be suspended or continued but your health insurance must be through your active employment.	• You must elect SHBP coverage as an active employee.
Active Employee Returning to Retiree Status	• You MUST complete the Retiree/Surviving Spouse Form to set up your deductions through the applicable retirement system again.	• Annuitant coverage maybe reinstated if you notify DCH/SHBP Division within 60 days. You must have continuous coverage, based on the conditions that first made you eligible as a retiree • Change coverage tier to You • Change Option

You or an Enrolled Dependent Turns Age 65

- Enrollment in Medicare is not required while actively working. However, once you stop working, premiums and options are based on enrollment in Medicare Part B. You will have 2 additional MA options. To receive the state subsidy, you will need to enroll in one of the MA options. You must enroll in Medicare Part B and continue to pay Part B premiums to enroll in a SHBP MA Option. A copy of your Medicare card should be submitted 30 days prior to the retirement or the month you or your covered spouse turns 65.

NOTE: The SHBP Medicare Advantage Plans include Part D prescription drug coverage

As an Active Employee

- Change coverage tiers.
- If no eligible dependent(s), discontinue coverage.

As a Retiree

- Discontinue your dependent(s) coverage or drop SHBP coverage. If you discontinue your SHBP coverage when you enroll for Medicare, you won't be able to enroll again for SHBP coverage unless you return to work in a position that offers SHBP coverage.
- Retirees may change to any available option upon becoming eligible for Medicare coverage but you will lose the state's contribution toward your health coverage if you do not enroll in a Medicare Advantage option at age 65
- See the Retiree Section 1.2 for more information.

OPEN ENROLLMENT

During Open Enrollment members must make their coverage choices for the upcoming Plan Year. If you do not take any action during Open Enrollment, you are deciding to choose the default coverage described in Open Enrollment materials posted on www.dch.georgia.gov/shbp if you are currently enrolled, and No coverage if you are not enrolled.

GENERAL INFORMATION ABOUT WHEN COVERAGE ENDS

The Board of Community Health may discontinue the SHBP and/or all benefit options at any time.

Certain employers may choose to stop offering SHBP coverage to employees or take actions that cause a termination of coverage for their employees:

Local school systems may withdraw from the plan for public school employees other than teachers. That means they can stop offering SHBP coverage to employees who are eligible for the plan for other public school employees and are not eligible for the plan for teachers.

State authorities participating in the ERS may stop offering SHBP coverage to employees and retirees, Charter schools that elected to offer SHBP coverage to employees may revoke that election through action or inaction (such as failure to pay required contributions) and thereby stop offering SHBP coverage to employees.

Employers that offer SHBP coverage to employees through a contract with DCH may stop offering SHBP coverage through action or inaction that causes the contract to terminate, and local school boards may stop offering SHBP coverage to school board members.

When coverage ends because the Board of Community Health discontinues the SHBP or because your employer stops offering the SHBP, this termination of coverage does not create continuation rights. However, you may have rights to continue coverage if you resign or retire while your employer still offers the Plan.

Whenever coverage ends for any reason, your entitlement to Benefits automatically ends on the date that coverage ends, even if you are hospitalized or are otherwise receiving medical treatment on that date.

When your coverage ends, we will still pay claims for Covered Health Services you received before your coverage ended. However, once your coverage ends, we do not provide Benefits for health services you receive for medical conditions that occurred after your coverage ended, even if the underlying medical condition occurred before your coverage ended.

An Enrolled Dependent's coverage ends on the date the Member's coverage ends.

EVENTS ENDING YOUR COVERAGE AS AN ACTIVE EMPLOYEE

Coverage ends on the earliest of the dates specified in the following table:

Who:	Your Coverage Will end If:	When:
For You	• You no longer qualify under category listed under the eligibility rules and your payroll deductions for coverage have ceased. • You do not make direct pay premium payments on time • You do not submit required premiums to your employer while you are on an unpaid leave of absence. • You resign or otherwise your employment ends • You are laid off because of a formal plan to reduce staff. • Your hours are reduced so that you are no longer eligible for benefits • You do not return to active work status after an approved unpaid leave of absence. • You are terminated by your employer. • You intentionally misrepresent eligibility for SHBP coverage for yourself or any covered dependents. • You intentionally misrepresent eligibility for waiver of the tobacco surcharge, either by failing to answer the question truthfully or failing to notify DCH/SHBP Division of a change to your answer during the year. • Member contributions that are not remitted to the Plan by the due date	• Coverage for Member ends at the end of the month following the month in which the last premium is deducted from your earned paycheck or at the end of paid coverage. Premiums will not be deducted from final leave pay. **NOTE**: If an Employing Entity fails to remit Premiums or documentation or fails to reconcile bills in the manner required by the Plan, the Plan may suspend coverage for all Enrolled Members of the Employing Entity. During a period of suspended coverage, benefits will continue to be paid, but the Employing Entity will be directly responsible for reimbursing SHBP for all claims paid. If the Employing Entity fails to provide the required Premiums or documentation or reconcile bills, coverage may be terminated for all Enrolled Members of the Employing Entity. In this instance, DCH, SHBP Division will send a notice to Enrolled Members before the coverage is terminated. Although termination of coverage in this situation does not give rise to COBRA continuation rights, members who have a right to continue coverage after resignation or retirement under State law will be provided an opportunity to do so if they stop working for the Employing Entity while SHBP coverage is in place. • If you intentionally misrepresent eligibility for waiver of the tobacco surcharge,

Who:	Your Coverage Will end If:	When:
	may result in suspension and/or termination of coverage. • Your employer stops offering SHBP, either by action (such as withdrawing from the plan for public school employees other than teachers) or inaction (such as not paying required contributions).	coverage will end beginning on the date that your false response is discovered and new coverage will not be available for at least 12 months thereafter.
When Coverage May Be Continued. SHBP allows individuals to continue their SHBP coverage in certain situations when it would have otherwise ended. **NOTE:** This chart applies to most SHBP members; certain parts of the Georgia Code may stipulate other conditions for SHBP continuation. Member contributions not remitted to the Plan by the due date may result in suspension and/or termination of coverage.	• Leave your job with less than 8 years of service • Leave your job and: - Have at least 8 years of service.	- Continue coverage for up to 18 months under COBRA provisions - Continue coverage by: -submitting the Direct Pay Enrollment form within 60 days of when coverage would end -pay full cost of coverage until you start receiving an annuity under the retirement system (if applicable). -provide statement from retirement system verifying your service. -pay annuitant premium once annuity begins if you have notified DCH/SHBP Division to start your deductions from your annuity -except for participants covered under the Legislative Retirement System

Who:	Your Coverage Will end If:	When:
For Your Dependents **NOTE:** A divorced spouse or covered dependent may continue Plan coverage by electing COBRA continuation coverage, which is limited to 36 months of coverage. The dependent must request COBRA from the DCH/SHBP Division within 60 days of the qualifying event.	**Discontinuation of coverage for a spouse or other covered dependent(s) during Open Enrollment does not qualify as a COBRA event. In order for a spouse or other dependent(s) to be eligible for continuation of coverage under COBRA, the DCH, SHBP Division must be notified at the time the divorce is final. If a spouse's coverage is discontinued during Open Enrollment in anticipation of divorce, the former spouse may be able to elect COBRA coverage when the divorce is final.**	• Coverage for your dependents will end at the same time you lose coverage because you are no longer eligible • Coverage will end for children at age 26 unless disabled prior to age 26 and the appropriate documentation has been submitted and approved by DCH/SHBP Division.

Section 1.2:
Eligibility as a Former Employee With 8 Or More Years of Service Or As A Retired Annuitant: When Coverage As A Former Employee Or Retired Annuitant Begins and Ends

NOTE: This Section does not apply to individuals who have less than eight Years of Service with a state retirement system or who are eligible because they work for an entity that has joined the SHBP through a contract with DCH. The terms of the contract control.

This Eligibility Document does not contain specific information about the amount former employees and annuitants are required to pay for continuation of coverage. Premium rates are set by the Board of Community Health, usually on an annual basis.

Premium rates for former employees who are not annuitants usually reflect the entire cost of coverage plus an administrative fee. Premium rates for annuitants currently reflect a subsidy for certain options. The Board of Community Health is authorized to set premiums by resolution, and may change premium requirements at any time with advanced notice. The Board approved a change in the methodology for subsidizing premiums for annuitants and their dependents. The new methodology adjusts the subsidy for annuitant premiums based on Years of Service for future annuitants who had less than five Years of Service as of January 1, 2012. This change will impact employees who had less than five Years of Service as of January 1, 2012 when they retire with an annuity in the future. Information will be made available before annuitant premiums based on Years of Service apply to any annuitant. Current rates for active employees, former employees, annuitants are posted on the DCH website at www.dch.georgia.gov.

Plan Membership

This section includes Plan Membership, Plan options and Medicare information for enrolled annuitants and enrolled former employees as well as important points to consider if you are considering retiring with an annuity or resigning with eight or more Years of Service. All former employees and annuitants age 65 or older who choose to enroll in an SHBP option that is not a Medicare Advantage (MA) option will pay the full cost of SHBP coverage. See the *Retiree Decision Guide* for more information. SHBP defines an annuitant as an individual who has started drawing a monthly check from a State Retirement System. If your monthly annuity check is not large enough to pay the full premium, you may arrange with DCH, SHBP Division to make direct payments of the annuitant premium.

Disabled individuals under the age of 65 with Medicare Parts A and B have two additional Medicare Advantage options. Contact SHBP if you have been approved by Social Security for Medicare due to disability and are under the age of 65 to discuss your options and rates. If you will be drawing an annuity you can be covered under any SHBP plan and will pay the Annuitant premium.

Retirees have certain rights that active employees do not have. Refer to Section 1.6 for your more information about your rights and responsibilities.

This Section is broken down by the various scenarios under which benefits may be continued.

Eligibility

8+ Years of Service with a State Retirement System (but not eligible to draw an annuity in the future) – Direct Pay

- You may continue your health insurance after active employment ends by paying the State Extended Coverage premiums directly to DCH/SHBP Division.
- Your Plan options are the same as active employees unless you are age 65 and have Medicare Part B and you will then have two additional Medicare Advantage Options
- You must complete the Direct Pay Enrollment Form and remit monthly State Extended Coverage premiums to DCH/SHBP Division. Update text and make reference to two forms.

10+ Years of Service (and able to draw an annuity in the future) – Direct Pay

- You may continue your health insurance after active employment ends by paying the required State Extended Coverage premiums directly to DCH/SHBP Division.
- If you are over 60 and have a minimum of 10 years of service, you can draw an annuity.
- You must complete the Direct Pay Enrollment Form and remit monthly State Extended Coverage premiums to SHBP until you start drawing an annuity update text and make reference to two forms.
- You must continue paying the State Extended Coverage premiums directly to DCH, SHBP Division every month until you begin drawing an annuity and are able to pay the Annuitant premiums
- When you start drawing your annuity, you will need to notify DCH, SHBP Division in order to have the

8+ Years of Service (and able to draw an annuity in the future) – Direct Pay (continued)

premium
changed from the State Extended Coverage premium to the Annuitant premium and to set up deductions from your annuity check.

- You will need to confirm that the correct deduction comes out of your first annuity check.
- If your annuity check is too small for the Annuitant premiums to be deducted, then you will pay the Annuitant premiums directly to DCH, SHBP Division.

Eligibility As An Annuitant

You may be able to continue Plan coverage if you are enrolled in the Plan when you retire and are immediately eligible to draw a retirement annuity from any of these State Retirement Systems:

- Employees' Retirement System (ERS)
- Teachers Retirement System (TRS)
- Public School Employees Retirement System (PSERS)
- Local School System Teachers Retirement Systems
- Fulton County Retirement System (eligible Members)
- Legislative Retirement System
- Superior Court Judges or District Attorney's Retirement System

Important Note: Individuals who withdraw all money from their respective retirement system will not be able to continue health coverage as an annuitant. Eligibility for temporary extended coverage under COBRA provisions would apply, and individuals with eight or more Years of Service are eligible for ongoing continued coverage as describe in the next section.

Options and Rates when Eligible to Immediately Draw an Annuity

Under Age 65

- Plan options are currently the same as for active employees
- Rates are currently the same as for active employees
- If in ERS, TRS or PSERS Retirement Systems your coverage will automatically roll over into retirement.
-

SHBP
State Health Benefit Plan

Age 65+ and have Medicare Part B

- Premiums and options change at age 65.
- Plan options are currently the same as for active employees + two additional Medicare Advantage options.
- If you enroll in Medicare Part B at age 65, you may enroll in one of the SHBP Standard or Premium Medicare Advantage Options (currently subsidized) OR
- You may have one of the other SHBP options but you will pay the full cost (not subsidized).
- MA options include Medicare Parts A, B and D.
- The benefits paid under the MA options reflect what Medicare would have paid (except for some plan enhancements); therefore, it does not coordinate benefits with any Medicare.
- If you are enrolled in a SHBP MA Option and enroll in an individual MA, Part D Plan, or Medicare Supplement you may lose eligibility for SHBP coverage.
- If in ERS, TRS or PSERS Retirement Systems your coverage will automatically roll over into retirement.

Split Eligibility – One Person Under Age 65 and One Person 65 or Older With Medicare Part B

- Plan options are currently the same as for active employees, and, in addition, Medicare Advantage options are available to the person who purchases and maintains Medicare Part B
- If the person with Medicare Part B maintains Medicare Part B and enrolls in a Medicare Advantage option, coverage is currently subsidized, and an annuitant's dependent who is not eligible for Medicare Part B may enroll in any non-MA option on a subsidized basis.
- If any person age 65 or older enrolls in a non-MA option, the full cost of all coverage elected must be paid – there is no subsidized coverage.
- If receiving your first check from ERS, TRS or PSERS Retirement Systems, your coverage will automatically roll over into retirement
- If DCH, SHBP Division has received and processed your Medicare Part B information, we will roll your coverage to the MA Standard under your current health care vendor.
- If you have dependents not eligible for the MA option, their coverage will roll to the option they had at the time you became covered by the MA option

IMPORTANT NOTICE: The SHBP Medicare Advantage Plans include Part D prescription drug coverage.

SHBP will continue to pay primary benefits for former employees not enrolled in a Medicare Advantage Option at age 65 or older if there is no Medicare information on file.

NOTE: Individuals who have lived at least 5 years in the United States may purchase Medicare Part B coverage even if they did not contribute to Social Security or work the number of required quarters. Enrollment in Medicare Part B is required to enroll in a Medicare Advantage Option.

Applying for Coverage Continuation as an Annuitant

You must apply for continued coverage for yourself and Covered Dependents within 60 days of the date your coverage as an active employee ends. Application can be made by contacting the Plan's Eligibility Section at (800) 610-1863. **Failure to apply on time or failure to make the correct premium payments will permanently end your SHBP coverage.** Members receiving their first monthly annuity check from ERS, TRS, and PSERS will be automatically enrolled in the same option they had as an active employee, unless Medicare Part B coverage has been reported to SHBP. Retirees with Medicare Part B coverage on file will automatically be enrolled in the Medicare Advantage Standard Option. Currently, only the Medicare Advantage options are subsidized for annuitants over age 65 or who are eligible for Medicare Part B due to disability. The Board of Community Health establishes required premiums by resolution, and premiums may be changed at any time with advance notice.

Annuitants may request to change Plan options if the request is made within 31 days of retirement. You may request the change by going online at www.mySHBPga.adp.com or the SHBP Call Center at (800) 610-1863 to request a change.

When Coverage As A Former Employee (Non-Annuitant) Begins

You must apply for continued coverage for yourself and Covered Dependents within 60 days of the date your coverage as an active employee ends. Application can be made by

or your covered dependent is age 65 and elects to enroll in a non-MA option, you will pay the full cost of your coverage; there is no subsidy. Individuals with Medicare are not eligible for TRICARE Supplement option.

When Annuitant Coverage Begins

If you are eligible for a monthly annuity at the time you retire, your coverage as an annuitant starts immediately at retirement, provided that you have all required monthly annuitant premiums deducted from your monthly annuity check. If the annuity check is not large enough, you must pay all required annuitant premiums directly to DCH, SHBP Division. **NOTE:** You must have continuous SHBP coverage from active employee status to annuitant status. If for some reason, there is a delay in your annuity being setup resulting in a gap of coverage, you must remit required annuitant premiums for this period in order to have health insurance as an annuitant. If required payments are not received on time, your coverage will be terminated with no right to reinstatement of coverage.

NOTE: If you discontinue coverage at the time you retire or at a later date, you will not be able to get this coverage back unless you return to work in a position that offers SHBP coverage.

When Will Coverage as an Annuitant or Former Employee End?

For You

- My coverage will end if I choose to cancel my coverage
- My coverage will end if I am paying SHBP directly for my premiums and I stop paying
- My coverage will end if I intentionally misrepresent my

contacting the Plan's Eligibility Section at: (800) 610-1863 and select option 3 the COBRA and payment line. If you elect to continue coverage as a former employee with 8 or more Years of Service, your coverage as a former employee starts immediately upon resignation, provided that you make all required State Extended Coverage premium payments on time and submit required documentation to the DCH, SHBP Division on time. If required payments are not received on time, your coverage will be terminated with no right to reinstatement of coverage.

NOTE: If you discontinue coverage at the time you resign with 8 or more Years of Service or at a later date, you will not be able to get this coverage back unless you return to work in a position that offers SHBP coverage.

eligibility or the eligibility of my dependents, or if I intentionally misrepresent my eligibility for waiver of a tobacco surcharge in my responses to the surcharge question or failing to notify DCH, SHBP Division of a change to my responses that would make me ineligible for the waiver.

- My coverage may end if my former employer stops offering SHBP coverage.

For Your Dependents

Coverage for your dependents will end when:

- They are no longer eligible
- A Social Security Number is not provided by the deadline
- You change from You + Family to You coverage
- Your coverage ends
- When they are approved for coverage under PeachCare for Kids
- If you fail to verify within 45 days of the coverage effective date the dependents coverage eligibility will be removed and the coverage will not go into effect as requested date.

Keep in mind that if dependents are dropped from your coverage, you will not be able to enroll them again – unless you have a qualifying event. Loss of PeachCare or TRICARE Supplement coverage is a qualifying event to add your dependent(s). The request resulting from loss of TRICARE Supplement must be made within 31 day of loss of coverage and 60 days within loss of PeachCare for Kids coverage.

If your Medicare Advantage coverage is terminated by CMS due to enrollment in another plan or failure to pay Medicare Part B premiums, the DCH, SHBP Division will enroll you in the Bronze HRA option or the option in which your dependent is enrolled if you have a split contract. You will pay the total cost of coverage and will not receive any subsidy.

Retirees who intentionally misrepresent the response to the tobacco surcharge questions or fail to notify DCH, SHBP Division of changes to their responses will permanently lose their SHBP health insurance.

Continuing Dependent Coverage at Your Death (for Annuitants)

In the event of your death, your covered surviving spouse or eligible dependents should contact the applicable State Retirement System (ERS, TRS, PSERS, etc.) and the DCH, SHBP Division as soon as possible.

Continuation coverage as a surviving dependent is an alternative to COBRA coverage. For information about continuation coverage through COBRA, see Section 1.4.

Plan provisions vary for survivors:

If surviving spouse receives an immediate annuity from a State Retirement System

- Plan coverage may continue for the surviving spouse and any covered dependent children after your death
- Surviving spouse premiums (set by the Board of Community Health, and currently subsidized) will be deducted from the annuity
- Surviving spouse must send premium payments directly to DCH, SHBP Division if the annuity is not large enough to cover premium
- Surviving spouse's new dependents or new spouse *cannot* be added to survivor's coverage
- Surviving spouse who becomes eligible for SHBP coverage as an active employee must discontinue the surviving spouse coverage and enroll as an active employee.

- When a surviving spouse ends active employee status and returns to a surviving spouse status, the surviving spouse coverage may be reinstated after notifying DCH, SHBP Division within 31 days. The surviving spouse will be eligible to continue coverage, based on the conditions that first made him or her eligible as a surviving spouse.

If surviving child receives an immediate annuity from a State Retirement System

- Plan coverage may continue after your death
- Surviving child's premium (set by the Board of Community Health, and currently subsidized) will be deducted from the annuity
- Surviving child must send premium payments directly to DCH, SHBP Division if the annuity is not large enough to cover premium
- Surviving child's coverage will terminate when he or she no longer satisfies the definition of a dependent child
- Surviving child may not add dependents to the coverage
- Surviving child who becomes eligible for SHBP coverage as an active employee must discontinue the surviving child coverage and enroll as an active employee.
- When a surviving child ends active employee status and returns to a surviving child status, the surviving spouse child coverage may be reinstated after notifying DCH, SHBP Division within 31 days. The surviving child will be eligible to continue coverage based on the conditions that first made him or her eligible as a surviving child.

Surviving spouse does not receive an immediate annuity from a State Retirement System

- Plan coverage may continue after your death if surviving spouse was married to you at least one year before your death
- Surviving spouse must send surviving spouse premiums (set by the Board of Community Health, and currently subsidized) directly to the DCH, SHBP Division
- Coverage ends if surviving spouse remarries
- Coverage ends for surviving child if he/she does not receive an annuity and there is no surviving spouse
- Plan coverage may continue under COBRA provisions See Section 1.4 for details

Making Changes to Your Retiree Coverage (for all Former Employees and Annuitants)

You can make changes to your coverage tier only at these times:

- Within 31 days of a qualifying event
  - You may add a dependent as long as the change is consistent with the qualifying event
  - You have 90 days from date of qualifying event to add and provide verification documents for a newly eligible dependent child
- During the annual Retiree Option Change Period
  - You may change your Plan option only

- Re-enrollment of yourself or your dependents is only permitted as described below.
- Adding dependents are not permitted unless you have a qualifying event as described below. You can decrease your tier at any time.

Discontinuing Your Retiree Coverage or Discontinuing Your Dependent Coverage (for all Former Employees and Annuitants)

You can discontinue coverage at any time. If you discontinue coverage you may never re-enroll in the SHBP as a former employee or annuitant unless you discontinued SHBP coverage due to enrollment in TRICARE Supplemental coverage offered by SHBP and maintained continuous coverage under the TRICARE Supplemental coverage until re-enrollment in SHBP coverage during a Retiree Option Change Period.

You may discontinue coverage for your dependents at any time. However, you may never re-enroll dependents in SHBP coverage unless you discontinued the dependent child's SHBP coverage due to enrollment of your dependent child in PeachCare for Kids and the dependent child has maintained continuous coverage under SHBP or PeachCare for Kids until re-enrollment in SHBP coverage during a Retiree Option Change Period. Except as described above, if you discontinue SHBP coverage for yourself or your dependents, you will not be able to get the coverage back unless you return to work in a position that offers SHBP coverage.

SHBP
State Health Benefit Plan

Qualifying Events for All Former Employees and Annuitants

Examples of a qualifying event are getting married, having a baby or spouse loses eligibility for health insurance. If you experience a qualifying event, you must request a coverage change within 31 days of the qualifying event (45 days for a newly eligible dependent child) by:

- Contacting the DCH, SHBP Division directly
- Returning the necessary form(s) with any requested documentation and the dependent's Social Security Number (SSN) to the Plan by the deadline.

* Fill out the form(s) completely. The Centers of Medicare & Medicaid Services (CMS) require DCH, SHBP Division to capture the SSN for all dependents. SHBP will provide coverage for a dependent to age two without a SSN.

If you miss the deadline, you will not have another chance to make the desired change. If the deadline is met, your change will take effect on the first day of the month following the receipt of your request, unless indicated in the chart below.

* **Do not delay submitting the form requesting change, even if you are waiting on documentation. Request must be made within 31 days of qualifying event.**

If you have this Qualifying Event:		You may…
You retire and immediately qualify for an annuity from a State Retirement system **Coverage must be continuous from active to annuitant status**	• Your coverage will automatically roll from active to annuitant status if in ERS, TRS, or PSERS	• Change to any available Plan option • Discontinue Coverage

If you have this Qualifying Event:		You may…
If your State Retirement System annuity check no longer covers the premium for your health coverage	• You will be changed to a direct pay status and the premium will include an administrative fee. • You will pay DCH, SHBP Division monthly for your health coverage.	• Change to any available Plan option • Discontinue coverage •
You or dependent turn 65 **NOTE:** You will lose your SHBP MA coverage if you enroll in an individual Medicare Advantage Plan, a Part D plan, Medicare Supplement plan or stop paying Medicare Part B premiums. As a result of these actions, DCH/SHBP Division will put you in the Bronze option or the Non-MA option in which your dependent is enrolled if you have a split contract, and you will pay the total cost of coverage for that option.	• You must go online at www.mySHBPga.adp.com and enter your Medicare Standard dates for Parts A and B and your Medicare number. Failure to submit a copy of your Medicare Part B enrollment will result in an increase in premiums to the full cost of coverage	• The person who turns 65 may choose from the Medicare Advantage Standard Plan or the Medicare Advantage Premium Plan. • The person who turns 65 may remain in a non-MA Plan option, and the full cost of coverage must be paid. • The person who turns 65 may Discontinue SHBP coverage but will not be eligible to reenroll Dependents under age 65 will no longer be eligible. **NOTE**: If your mailing address in SHBP records is a PO Box, CMS will not approve your enrollment into a MA Plan. You will remain in your current Plan option and must pay the full cost of coverage (without any subsidy) until you provide a Street Address and CMS approves your enrollment into a MA plan.

SHBP
State Health Benefit Plan

If you have this Qualifying Event:		You may…
Spouse or enrolled dependent's employment status changes, affecting coverage eligibility under a qualified health plan	• Within 31 days of qualifying event • Provide a letter from the other plan documenting loss/gain of coverage and reason for loss of coverage is required. You will need to furnish the Social Security Number for each dependent you wish to cover.	• Change coverage tier • Add your eligible dependent(s) • Fax dependent verification documentation within 45 days of qualifying event
Divorce		• Must remove spouse from coverage • Must remove stepchildren from coverage • Change coverage tier
You and spouse are both annuitants receiving annuity checks from State Retirement Systems and you each have annuity checks large enough to have annuitant premiums deducted		• May change at any time from You+ Family coverage to each having You Only coverage; a request to change to You Only for you and your spouse must be filed at the same time by calling the SHBP Member Services Center at 1-800-610-1863.
Loss of dependent(s) that impacts your Tier (i.e. loss of all eligible dependents – you may change tiers to your coverage)	• Loss of dependent that affects your current tier	• Change coverage tier

SHBP
State Health Benefit Plan

If you have this Qualifying Event:		You may…
If you are working in a benefits eligible position and are continuing to receive your annuity from a State Retirement System	• You must advise DCH, SHBP Division when you terminate your benefits eligible position or you will not have health coverage as an annuitant. • You need to notify SHBP to restart your health insurance deductions from your retirement check by contacting SHBP's Member Services Center at 1-800-610-1863.	• You must have coverage as an active employee • You must follow the active coverage rules as long as you are working in a SHBP benefits eligible position **NOTE**: Once you terminate your SHBP benefits eligible position you must follow the plan rules for annuitants
Acquire dependent because of marriage, or Qualified Medical Child Support Order (QMCSO) approved by DCH, SHBP Division	• Within 31 days of qualifying event (90 days for a newly eligible dependent child)	• Change coverage tier to add the dependents • Add your eligible dependent(s) • Fax dependent verification documentation within 45 days of qualifying event
Acquire dependent because of birth/adoption	• Within 31 days of qualifying event (90 days for a newly eligible dependent child)	• Change coverage tier to add the dependents • Add your eligible dependent(s) • Fax dependent verification documentation within 45 days of qualifying event
	• Within 31 days of qualifying event	• Change coverage tier to add the spouse

If you have this Qualifying Event:		You may…
Spouse's loss of eligibility for health insurance due to retirement **NOTE**: Retirement without loss of eligibility for health insurance, discontinuation of coverage, reduction of benefits, or change in premiums ARE NOT qualifying events. Loss of eligibility for health insurance at retirement is a qualifying event.	• Provide a letter from the other plan documenting loss of coverage and reason for loss of coverage is required. You will need to furnish the Social Security Number for each dependent you wish to cover.	• Add your eligible spouse

If you have this Qualifying Event:		You may…
Your spouse or enrolled dependent are covered under a qualified health plan and you lose eligibility, such as through other employment, Medicaid*, State Children's Health Insurance Program (SCHIP) or Medicare	• Furnish Social Security Number and dependent verification for each dependent you wish to cover • Letter from other employer, Medicaid or Medicare documenting date and reason for loss of discontinuation required.	• Change coverage tier • Enroll eligible dependent(s) • Fax dependent verification documentation within 45 days of the qualifying event. **NOTE**: For loss of Medicaid or SCHIP coverage, you have 60 days for actions above.

Retiree Option Change Period (ROCP)

During the Retiree Option Change Period (ROCP), generally from mid-October to mid-November each Plan year, you can make these changes to your coverage:

- Select a new coverage option
- Change to a lower tier
- Discontinue coverage

(**NOTE**: Re-enrollments are not allowed.)

Changes will take effect the following January 1st.

If You Return to Active Employee Status

If you choose to return to active service with an employing entity under the Plan, whether immediately after you retire with an annuity or at a later date, your retirement annuity may be suspended or continued. SHBP coverage, however, must be purchased as an active employee with payroll deduction by your employer. You will need to complete enrollment online paperwork with your employer and verify the deduction stopped with the retirement system.

When you return to retired status, retiree coverage will only be reinstated after notifying the DCH, SHBP Division within 31 days if you have continued to receive your retirement annuity. You will be eligible for continuous coverage, based on the conditions that first made you eligible as a retiree.

If you retired before the initial legislative funding for a particular employee group, you will not be entitled to annuitant coverage unless the final service period qualifies you for a monthly annuity from a State Retirement System.

Special Note: Re-enrollment into retiree coverage is not automatic if you continued to receive your retirement annuity check. You must request retiree coverage within 31 days of loss of active coverage or you will lose eligibility for retiree coverage.

Medicare Coordination of Benefits for all Former Employees and Annuitants

SHBP will coordinate benefits with Medicare on non-Medicare Advantage options. Under Georgia law, the SHBP is required to subordinate health benefits to Medicare benefits (for non-MA plans).

If you enroll in Medicare Advantage option after becoming eligible for Medicare, the Medicare Advantage plan will pay the Medicare approved benefits and any additional benefits SHBP has made to this Plan. Since this Plan is a Medicare approved plan, this Plan does not coordinate benefits with Medicare. If you are retired and are enrolled in a SHBP non-Medicare Advantage option, SHBP will coordinate benefits with Medicare. Under Georgia law, SHBP is required to subordinate health benefits to Medicare benefits (for non-MA plans).

The chart below provides important details related to primary and secondary coverage based on your Medicare status (for you and/or your dependents that are not enrolled in a Medicare Advantage plan):

If you are retired and…	**The Plan will pay…**
• … age 65, consider enrolling in Medicare Parts A, B and D two months prior to the month in which you turn 65 to maximize coverage.	• Secondary benefits starting on the first day of the month in which you turn 65.
• …age 65, Medicare eligible and do not enroll in Part A, Part B and Part D	• Primary benefits; however, Plan premium will increase significantly.
• … age 65 or older and not entitled to Medicare (because have not lived in the U.S. for 5 years or longer)	• Primary benefits; however, Plan premium will increase significantly
• … age 65 or older and have dependents not entitled to Medicare because of age	• Primary benefits for dependents.

The SHBP is not a supplemental plan to Medicare. The Plan will pay secondary benefits/coordinate benefits if retired and enrolled in Medicare and a non-Medicare Advantage option. The Plan does not pay secondary benefits with the Medicare Advantage Options.

All other Plan options pay benefits after Medicare pays benefits. That means that any Medicare coverage you or your dependents have will be the primary plan and the SHBP option you have will be the secondary plan. To maximize coverage, you and your dependents should consider enrolling in Medicare Parts A, B and D two months before the month in which you turn 65.

See the SPD for information about coordination of benefits with plans other than Medicare.

SHBP
State Health Benefit Plan

Frequently Asked Medicare Questions

1. Are you not yet eligible for Medicare?
   - Annuitant health premiums are currently similar to those of active employees
   - Former employees with more than 8 Years of Service pay State Extended Coverage premiums
2. Are you eligible or about to be eligible for Medicare?

   - Medicare is the country's health insurance program for people age 65 or older who qualify based on Medicare eligibility rules. Medicare also covers certain people with disabilities who are under age 65 and people of any age who have permanent kidney failure. Medicare becomes your primary insurance carrier once you are covered by Medicare. You are eligible for Medicare even if you never paid into Social Security. You and/or your spouse can purchase Medicare Part B if you are a U.S. Citizen, reside in the U.S., age 65 or older (or a legal non-citizen, age 65 or older, who resides and has lived in the U.S. for at least 5 years or longer)
   - You will need to go online at: www.mySHBPga.adp.com and enter your Medicare Part A and B start date, Medicare Number and elect your MA option if you want to continue to receive subsidized coverage

Due to Disability

- If you are disabled under Social Security, you may qualify for Medicare after a waiting period.

Medicare information is available at:

- www.cms.gov
- www.medicare.gov
- www.ssa.gov
- 1-866-552-4464 (Georgia Cares)
- 1-800-633-4227 (Medicare)

Section 1.3: Appeals

Appeal Process – How to Appeal an Eligibility Decision

The Plan Administrator, Department of Community Health, SHBP Division has the final decision-making power for eligibility appeals.

Generally, a decision is issued within 90 days following receipt; however, the number of days may be extended by notice from the DCH, SHBP Division. The written notice of the decision by DCH SHBP is the final step in the proceedings and will exhaust all administrative remedies.

The appeal forms are available on the website at www.dch.georgia.gov/shbp . All member correspondence sent to the DCH, SHBP Division should include the enrolled member's last four numbers of the Social Security Number (SSN), or the identification number on your health ID card to prevent a delay in processing your request.

Call the SHBP's Member Services Center and ask for a review. If you disagree with the results of the review, you may file a written request.

To file a formal request for review, complete and sign the Appeals Review form and send supporting information of the denied action within 60 days.

Section 1.4: Continuation of Coverage Under COBRA and During Leave

This section provides you with information about all of the following:

- Continuation of coverage under federal law (COBRA)
- Continuation of coverage during approved unpaid leaves of absence.

When Coverage May Be Continued

Certain situations allow you to continue your SHBP coverage temporarily. If you have eight or more Years of Service, you may have additional rights to continue coverage. See Section 1.2 for important information.

Unpaid Leaves of Absence

If you are an active employee on an approved unpaid leave, you may be able to continue your current coverage for up to 12 calendar months – or longer for military leave.

Unpaid leave is available for:

- Disability/illness – more details below
- Educational instruction
- Employee's convenience
- Employer's convenience
- Family medical reasons as provided under the Family and Medical Leave Act (FMLA) – more details below
- Military duty (emergency and voluntary) – more details below
- Suspension of employment

You will have to meet certain requirements for each leave type and your personnel/payroll office can provide you with the necessary information, including premium rates and a *Request to Continue Health Benefits During Leave of Absence Without Pay* form. Also, most leave types require supporting documentation which you will supply to your employer.

You can apply for continued coverage within 31 days after starting an unpaid leave.

NOTE: You cannot go onto the year round web portal to make a COBRA election. You must return the COBRA form you receive from SHBP. If you do not have a COBRA form, you can request one from the SHBP Member Services Center at 1-866-610-1863 and select COBRA option from the prompt.

Continuing Coverage during Approved Disability Leave

In case you become disabled while an active employee, the Plan has provisions that may allow you to continue coverage, which are described in the table below:

Because of a disability, you have this situation:	You will be affected in this way:
• You are Totally Disabled and are on an approved disability leave OR • You return to work on a part-time basis before the end of your approved disability leave and before returning to full-time work.	• You will be eligible to continue health benefits for up to 2 months • You will pay the same premium amount you paid while actively working, but you must pay premiums directly to your employer Coverage is limited to the disability period that you physician certifies, You must provide the applicable documentation of your disability period to your employer

If you are a disabled, retired Member, see “Provisions for Eligible Retirees” for more information on how your coverage may be affected.

Continuing Coverage under Family and Medical Leave Act (FMLA)

You may continue medical coverage for yourself and your dependents for up to 12 weeks after the start of your leave for specific medical and/or family medical reasons if your employer has approved your leave as FMLA leave. Forms for continuing your coverage are available from your personnel/payroll office.

During FMLA leave without pay, you will pay the same premium amount you paid while actively working, but you must send your premium payment directly to your employer. How FMLA affects your coverage depends on the circumstances involving your leave.

If you have this situation:	You will be affected in this way:
• Choose not to continue coverage while on leave • Open Enrollment period occurs while on leave	• Claims will not be paid by SHBP for a period after coverage terminates and while you remain on leave. You are responsible for paying the Providers. • You must resume coverage when you return to work. • If you continue coverage while on leave, you may change coverage as permitted during Open Enrollment • If you do not continue coverage while on leave, contact your employer.

If you have this situation:	You will be affected in this way:
	For Open Enrollment information
• Do not return to work after your leave ends and you have paid your premiums directly to your employer during your leave	• You may be eligible to continue your health benefits through COBRA

Continuing Coverage during Military Leave

If you are on certain kinds of military leave described by federal law, you and your dependents may continue coverage by paying the same premiums you paid while actively working. However, these premiums must be paid directly to your employer. Your employer is responsible for approving your military leave and collecting premiums from you.

You may elect to discontinue coverage while on leave. The DCH, SHBP Division will reinstate your coverage when you return to employment after military service. However, for the time period allowed by the Veteran's Administration, the Plan does not cover care for a Member's illness or injury that the Secretary of Veteran's Affairs determined was acquired or aggravated during the military leave.

If You Leave Your Job With Less than 8 Years of Service

This chart shows how your coverage would be affected if you were to leave your job with less than 8 Years of Service. Please see Section 1.2 for information about leaving your job with 8 or more Years of Service.

If you have this situation:	You will be affected in this way:
• Leave your job • Take another job with your employment that does not qualify you for coverage • Move to part-time status with hours below the minimum required for eligibility • Are laid off or otherwise terminated employment	• You can continue coverage for up to 18 months under COBRA provisions

See provisions for Eligible Retirees for more information about how coverage is affected when you leave your job and are immediately eligible to draw a retirement annuity.

In the Event of Your Death During Active Employment

As described below, surviving dependents may continue coverage temporarily through COBRA. Note: If your surviving enrolled dependents are able to receive a retirement plan annuity (a monthly check), see Section 1.2 for important information about extra rights they may have. The cost of continuing coverage as a surviving dependent with an annuity may be much lower than the cost of COBRA continuation. Surviving dependents must apply for survivor continuation coverage within ninety days of the Member's death. If a surviving dependent chooses survivor continuation coverage, he or she waives the right to continue coverage under the COBRA rules.

See Section 1.2 for information on survivor coverage in the event of the death of a former employee with more than 8 Years of Service.

Continuation Coverage under Federal Law (COBRA)

Much of the language in this section comes from the federal law that governs continuation coverage.

In order to be eligible for continuation coverage under federal law, you must meet the definition of a "Qualified Beneficiary". A Qualified Beneficiary is any of the following persons who was covered under the Plan on the day before a qualifying event:

- A Member
- A Member's Enrolled Children, Step-children, or legal child
- A Member's covered spouse.

Qualifying Events for Continuation Coverage under Federal Law (COBRA)

If the coverage of a Qualified Beneficiary would ordinarily terminate due to one of the following qualifying events, then the Qualified Beneficiary is entitled to continue coverage. The Qualified Beneficiary is entitled to elect to continue the same coverage that she or he had on the day before the qualifying event. When a Qualified Beneficiary has elected COBRA continuation coverage that the coverage can be extended due to a second qualifying event.

The qualifying events are:

A. Termination of the covered Member from employment with us, for any reason other than gross misconduct, or reduction of hours below the minimum hours required for eligibility, or transfer to a position for which SHBP coverage is not offered; or
B. Death of the Member; or
C. Divorce from the Member; or
D. Loss of eligibility by an Enrolled Dependent who is a child; or
E. Entitlement of the Member to Medicare benefits; or
F. The Plan Sponsor filing for bankruptcy, under Title XI, United States Code, on or after July 1, 1986, but only for a retired Member and his or her Enrolled Dependents. This is also a qualifying event for any retired Member and his or her Enrolled Dependents if there is a substantial elimination of coverage within one year before or after the date the bankruptcy was filed.

Notification Requirements and Election Period for Continuation Coverage under Federal Law (COBRA)

The Member or other Qualified Beneficiary must notify DCH, SHBP Division within 60 days of the Member's divorce, or an Enrolled Dependent's loss of eligibility as an Enrolled Dependent. If the Member or other Qualified Beneficiary fails to notify DCH, SHBP Division of these events within the 60 day period, there is no right to continue coverage under COBRA. In addition, failure to notify DCH, SHBP Division that a dependent has lost eligibility is an intentional misrepresentation, and will be grounds for terminating coverage for the Member and the dependent.

If a Member or other Qualified Beneficiary is already continuing coverage under COBRA, the Member or other Qualified Beneficiary must notify the DCH, SHBP Division within 60 days of the birth or adoption of a child. Failure to notify the DCH, SHBP Division within the 60 day period will result in loss of the right to add the new child to the COBRA coverage.

Once DCH, SHBP Division receives notification of divorce or loss of dependent eligibility from the Member or Qualified Beneficiary, coverage will be terminated for the former spouse or dependent that lost eligibility retroactive to the end of the month in which the qualifying event occurred. A COBRA election notice will be mailed to the Member or Qualified Beneficiary. If a complete, signed election of continuation coverage is submitted to DCH, SHBP Division by the later of 60 days after the qualifying event occurs or 60 days after the Qualified Beneficiary receives the COBRA election form from SHBP, COBRA coverage will be provided upon payment of required COBRA premiums.

The initial premium due to SHBP must be paid on or before the 45th day after electing continuation.

Notification Requirements for Disability Determination or Change in Disability Status

The Member or other Qualified Beneficiary must notify DCH, SHBP Division as described under "Terminating Events for Continuation Coverage under federal law (COBRA)", subsection A. below.

The notice requirements will be satisfied by providing written notice to DCH, SHBP Division at the address stated in Attachment II to this Eligibility Document. The contents of the notice must be such that SHBP is able to determine the covered employee and Qualified Beneficiary or Qualified Beneficiaries, the qualifying event or disability, and the date on which the qualifying event occurred.

After providing notice to the DCH, SHBP Division, the Qualified Beneficiary shall receive the continuation coverage and election notice. Continuation coverage must be elected by the later of 60 days after the qualifying event occurs; or 60 days after the Qualified Beneficiary receives notice of the continuation right from SHBP.

The Qualified Beneficiary's initial premium due to SHBP must be paid on or before the 45th day after electing continuation.

The Trade Act of 2002 amended COBRA to provide for a special second 60-day COBRA election period for certain Members who have experienced a termination or reduction of hours and who lose group health plan coverage as a result. The special second COBRA election period is available only to a very limited group of individuals: generally, those who are receiving trade adjustment

assistance (TAA) or 'alternative trade adjustment assistance' under a federal law called the Trade Act of 1974. These Members are entitled to a second opportunity to elect COBRA coverage for themselves and certain family members (if they did not already elect COBRA coverage), but only within a limited period of 60 days from the first day of the month when an individual begins receiving TAA (or would be eligible to receive TAA but for the requirement that unemployment benefits be exhausted) and only during the six months immediately after their group health plan coverage ended.

If a Member qualifies or may qualify for assistance under the Trade Act of 1974, he or she should contact SHBP for additional information. The Member must contact SHBP promptly after qualifying for assistance under the Trade Act of 1974 or the Member will lose his or her special COBRA rights. COBRA coverage elected during the special second election period is not retroactive to the date that Plan coverage was lost, but begins on the first day of the special second election period.

Terminating Events for Continuation Coverage under Federal Law (When COBRA Coverage Ends)

COBRA, continuation coverage under the Plan will end on the earliest of the following applicable dates:

A. Eighteen months from the date of the qualifying event, if the Qualified Beneficiary's coverage would have ended because the Member's employment was terminated or hours were reduced (i.e., qualifying event A.). If a Qualified Beneficiary is determined to have been disabled under the Social Security at any time within the first 60 days of continuation coverage for qualifying event A then the Qualified Beneficiary may elect an additional 11 months of continuation coverage (for a total of 29 months of continued coverage) subject to the following condition: (i) notice of such disability must be provided within 60 days after the determination of the disability, and in no event later than the end of the first 18 months; (ii) the Qualified Beneficiary must agree to pay any increase in the required premium for the additional 11 months; and (iii) if the Qualified Beneficiary entitled to the 11 months of coverage has non-disabled family members who are also Qualified Beneficiaries, then those non-disabled Qualified Beneficiaries are also entitled to the additional 11 months of continuation coverage. Notice of any final determination that the Qualified Beneficiary is no longer disabled must be provided within 30 days of such determination. Thereafter, continuation coverage may be terminated by the Plan on the first day of the month that begins more than 30 days after the date of that determination.

B. Thirty-six months from the date of the qualifying event for an Enrolled Dependent whose coverage ended because of the death of the Member, divorce of the Member, or loss of eligibility by an Enrolled Dependent who is a child (i.e. qualifying events B., C., or D.).

C. For the Enrolled Dependents of a Member who was entitled to Medicare prior to a qualifying event that was due to either the termination of employment or work hours being reduced, eighteen months from the date of the qualifying event, or, if later, 36 months from the date of the Member's Medicare entitlement, whichever is later.

D. The date coverage terminates under the Plan for failure to make timely payment of the premium.

Act

E. The date, after electing continuation coverage, where coverage is first obtained under any other group health plan. If such coverage contains a limitation or exclusion with respect to any pre-existing condition, continuation shall end on the date such limitation or exclusion ends. The other group health coverage shall be primary for all health services except those health services that are subject to the pre-existing condition limitation or exclusion.

F. The date, after electing continuation coverage, that the Qualified Beneficiary first becomes entitled to Medicare, except that this shall not apply in the event that coverage was terminated because the Plan Sponsor filed for bankruptcy, (i.e. qualifying event F.).

G. The date the entire Plan ends or the date the employer stops offering SHBP coverage.

H. The date coverage would otherwise terminate under the Plan as described in this section under the heading Events Ending Your Coverage.

If a Qualified Beneficiary is entitled to 18 months of continuation and a second qualifying event occurs during that time, the Qualified Beneficiary's coverage may be extended up to a maximum of 36 months from the date coverage ended because employment was terminated or hours were reduced below the minimum hours for Plan eligibility. If the Qualified Beneficiary was entitled to continuation because the Plan Sponsor filed for bankruptcy, (i.e. qualifying event F.) and the retired Member dies during the continuation period, then the other Qualified Beneficiaries also shall be entitled to continue coverage for 36 months from the date of the Member's death. Terminating events B through G described in this section will apply during the extended continuation period.

Continuation coverage for Qualified Beneficiaries whose continuation coverage terminates because the Member becomes entitled to Medicare may be extended for an additional period of time. Such Qualified Beneficiaries should contact the DCH, SHBP Division for information regarding the continuation period.

Section 1.5:
General Legal Provisions

This section provides you with information about:
- General legal provisions concerning the Plan

Plan Document

If there are discrepancies between the information in this Eligibility Document and DCH Board regulations or the laws of the state of Georgia, those regulations and laws will govern at all time.

Relationship with Providers

The relationships between SHBP, BCBSGa, Unitedhealthcare of Georgia, Healthways, and ESI, and Network providers are solely contractual relationships between independent contractors. Network providers are not our agents or employees; nor are they agents or employees of BCBSGa, UnitedHealthcare of Georgia, Healthways, and ESI. Neither we nor any of our employees are agents or employees of Network providers.

We do not provide health care services or supplies, nor do we practice medicine. Instead, we pay Benefits for Covered Services. Network providers are independent practitioners who run their own offices and facilities. The credentialing process confirms public information about the providers' licenses and other credentials, but does not assure the quality of the services provided. Network providers are not our employees or employees of BCBSGa, UnitedHealthcare of Georgia, Healthways, or ESI; nor do we have any other relationship with Network providers such as principal agent or joint venture. Neither we, BCBSGa, UnitedHealthcare of Georgia, Healthways, nor ESI is liable for any act or omission of any provider.

BCBSGa, UnitedHealthcare of Georgia, Kaiser Permanente of Georgia, Healthways, and ESI are not considered to be employers of the SHBP for any purpose with respect to the administration or provision of benefits under this Plan. Your employer is solely responsible for proper classification of your employment.

BCBSGa, Unitedhealthcare of Georgia, Kaiser Permanente of Georgia, Healthways, and ESI are solely responsible for timely processing of benefits.

The Plan Administrator, DCH, through the DCH, SHBP Division and your employer are jointly responsible for notifying you of the termination or modification of the Plan.

Your Relationship with Providers

The relationship between you and any provider is that of provider and patient.

- You are responsible for choosing your own provider.
- You must decide if any provider treating you is right for you. This includes Network providers you choose and providers to whom you have been referred.
- You must decide with your provider what care you should receive.
- Your provider is solely responsible for the quality of the services provided to you.

The relationship between you and us is that of Plan Sponsor and employee, Dependent or other classification as defined in the Plan.

Incentives to You

Sometimes BCBSGa, UnitedHealthcare of Georgia, Kaiser Permanente of Georgia, Healthways, and ESI may offer incentives to encourage you to participate in various wellness programs or certain disease management programs. The decision whether or not to participate is yours alone, but we recommend that you discuss participating in such programs with your physician. These incentives are not Benefits and do not alter or affect your Benefits. Contact BCBSGa, Unitedhealthcare of Georgia, Kaiser Permanente, Healthways, or ESI if you have any questions.

Interpretation of Benefits

SHBP, BCBSGa, Unitedhealthcare of Georgia, Kaiser Permanente, Healthways, and ESI have sole and exclusive discretion to do all of the following:

- Interpret Benefits Provisions. SHBP has delegated to BCBSGa, Unitedhealthcare of Georgia, Kaiser Permanente, Healthways, and ESI the sole authority to interpret the Plan as necessary to pay claims.
- Interpret the other terms, conditions, limitations and exclusions of the Plan, including this Eligibility Document and any [Riders] and Amendments.
- Make factual determinations related to the Plan and its Benefits.

SHBP BCBSGa, Unitedhealthcare of Georgia, Kaiser Permanente, Healthways, and ESI may delegate this approval. You must cooperate with those persons or entities in the performance of their responsibilities.

Clerical Error

If a clerical error or other mistake occurs, that error does not create a right to Benefits. These errors include, but are not limited to, providing misinformation on eligibility or Benefit coverage's or entitlements. It is your responsibility to confirm the accuracy of statements made by us or our designees, including BCBSGa, Unitedhealthcare of Georgia, Kaiser Permanente, Healthways, or ESI, in accordance with the terms of this Eligibility Document and other Plan documents.

Information and Records

At times SHBP, BCBSGa, Unitedhealthcare of Georgia, Kaiser Permanente, Healthways, or ESI may need additional information from you. You agree to furnish us and/or BCBSGa, Unitedhealthcare of Georgia, Kaiser Permanente, Healthways, or ESI with all information and proofs that we may reasonably require regarding any matters pertaining to the Plan. If you do not provide this information when we request it, we may delay or deny payment of your Benefits.

By accepting Benefits under the Plan, you authorize and direct any person or institution that has provided services to you to furnish SHBP, BCBSGa, Unitedhealthcare of Georgia, Kaiser Permanente, Healthways, or ESI with all information or copies of records relating to the services provided to you. SHBP, BCBSGa, Unitedhealthcare of Georgia, Kaiser Permanente, Healthways, or ESI have the right to request this information at any reasonable time. This applies to all

discretionary authority to other persons or entities that provide services in regard to the administration of the Plan.

Administrative Services

We may, in our sole discretion, arrange for various persons or entities to pr0ovide4 administrative services in regard to the Plan, such as claims processing. The identity of the service providers and the nature of the services they provide may be changed from time to time in our sole discretion. We are not required to give you prior notice of any such change, nor are we required to obtain your SHBP, BCBSGa, Unitedhealthcare of Georgia, Kaiser Permanente, Healthways, and ESI have the right to release any and all records concerning health care services which are necessary to implement and administer the terms of the Plan, for appropriate medical review or quality assessment, or as we are required to do by law or regulation. During and after the term of the Plan, SHBP, BCBSGa, Unitedhealthcare of Georgia, Kaiser Permanente, Healthways, and ESI, and our related entities may use and transfer the information gathered under the Plan for research and analytic purposes.

For complete listings of your medical records or billing statements, we recommend that you contact your health care provider. Providers may charge you reasonable fees to cover their costs for providing records or completing requested forms.

If you request medical forms or records from us, we also may charge you reasonable fees to cover costs for completing the forms or providing the records.

In some cases, SHBP, Healthways, or ESI will designate other persons or entities to request records or information from or related to you, and to release those records as necessary. Such designees have the same rights to this information as SHBP.

Examination of Covered Persons

In the event of a question or dispute regarding your right to Covered Persons, including Enrolled Dependents whether or not they have signed the Member's enrollment form. SHBP, BCBSGa, Unitedhealthcare of Georgia, Kaiser Permanente, Healthways, and ESI agree that such information and records will be considered confidential.

Refund of Overpayments

If we pay Benefits for expenses incurred on account of a Covered Person, that Covered Person, or any other person or organization that was paid, must make a refund to us if either of the following apply:

- All or some of the expenses were not paid by the Covered Person or did not legally have to be paid by the Covered Person.
- All or some of the payment we made exceeded the Benefits under the Plan.

The refund equals the amount we paid in excess of the amount we should have paid under the Plan. If the refund is due from another person or organization, the Covered Person agrees to help us get the refund when requested.

If the Covered Person, or any other person or organization that was paid, does not promptly refund the full amount, we may reduce the amount of any future Benefits that are payable under the Plan. The reductions will equal the amount of the required refund. We may have other rights in addition to the right to reduce future benefits.

Limitation of Action

If you want to bring a legal action against SHBP, BCBSGa, Unitedhealthcare of Georgia, Kaiser Permanente, Healthways, or ESI, you must do so within three years from the expiration of the time period in which a request for reimbursement must be submitted or you lose any rights to bring such an action against SHBP, BCBSGa,

Benefits, we may require that a Network Physician of our choice examine you at our expense.

Workers' Compensation not Affected

Benefits provided under the Plan do not substitute for and do not affect any requirements for coverage by workers' compensation insurance.

You cannot bring any legal action against SHBP, BCBSGa, Unitedhealthcare of Georgia, Kaiser Permanente, Healthways, or ESI for any other reason unless you first complete all the steps in the appeal process described in this document. After completing that process, if you want to bring a legal action against SHBP, BCBSGa, Unitedhealthcare of Georgia, Kaiser Permanente, Healthways, or ESI, you must do so within three years of the date you are notified of our final decision on your appeal, or you lose any rights to bring such an action against SHBP, BCBSGa, Unitedhealthcare of Georgia, Kaiser Permanente, Healthways, or ESI.

Section 1.6:
Your Rights and Responsibilities

Active Employee Rights and Responsibilities

Your Rights as an Employee Enrolled in Plan Coverage.

As an employee enrolled in Plan coverage, you have the right to:

- Have your eligible claims paid and notifications provided in a timely manner
- Receive information about the Plan and the options available to you
- Be informed of the process for filing appeals of denied claims
- Have access to Provider information
- Review your appeal file
- Examine, without charge, all documents governing the Plan at the Plan Administrator's office
- Request copies of the above documents, in writing, from the Plan Administrator (a reasonable copy fee may apply)
- Be informed by the Plan of how to continue your coverage if it would otherwise end in certain situations

Your Rights for Continuing Group Health Plan Coverage

You have the right to continue group health plan coverage if you lose Plan coverage due to a qualifying event. In this case, you may continue health care coverage for yourself, spouse or dependents; however, you or your dependents have to pay for such coverage. Review this Eligibility Document and other Plan documents governing your continuation coverage rights.

Your Responsibilities as an Employee Enrolled in Plan Coverage

This is a summary of some of the important responsibilities of employees enrolled in the Plan:

- **Make proper and timely premium payments.** Premium payments for active employees must be made through salary deductions. Premium payments for employees on leave must be made directly to the employer. It's your responsibility to make sure that your employer (the State, school district, agency, etc.) is deducting the right amount from your paycheck for your option and coverage tier. When you are first hired, and later during each Open Enrollment (or Retiree Option Change Period), you will receive premium information.

- **Make accurate choices when you make your enrollment selection.** After the Open Enrollment period ends, the SHBP will make changes only when there is a documented administrative error. Any premium refund will be limited to 12 months of premiums and is payable only after the Plan receives documented evidence from the Member that the Plan had no liability for additional covered persons.

Answer surcharge questions truthfully and notify DCH, SHBP Division immediately if the answers to your surcharge questions change during the year. Intentional misrepresentation in response to surcharge questions or failure to notify DCH, SHBP Division of changes to your responses to surcharge will have significant consequences. Active employees will lose State Health Benefit Plan coverage for 12 months beginning on the date that your false response or failure to notify is discovered. Retirees who intentionally misrepresent the response to the surcharge questions or fail to notify DCH, SHBP Division of changes to their responses will permanently lose their SHBP health insurance.

- **Take the time to understand how the Plan option works.** You are the manager of your health care needs and, therefore, you must take the time to understand your Plan option. You also are responsible for understanding the consequences of your decisions. Carefully review this booklet and the *Active Employee Decision Guide.* Having read the documents, you can take steps to maximize your coverage.

- **Know when and how your participation can end.** Generally, coverage ends when you no longer meet job classification or working hours requirements for eligibility or when you fail to make the proper premium payments. Coverage may also end if your employer fails to pay required contributions to the DCH, SHBP Division or if your employer decides to stop offering SHBP coverage to all employees or all employees in your job classification. For eligibility requirements and other circumstances that may result in loss of coverage, see Sections 1.1 & 1.2.

- **Notify DCH, the SHBP Division if you or any of your dependents are no longer eligible for coverage** If you misrepresent eligibility information when applying for coverage, during a change in coverage or when filing for benefits, or by paying for coverage on behalf of someone who is not eligible, adverse action may be taken against you by DCH or applicable enforcement agencies. Adverse actions include, but are not limited to: terminating your coverage, collection actions for all payments improperly made as a result of the misrepresentation, and criminal prosecution.
- **Notify DCH, SHBP Division of any address change and read all information sent to you by DCH, SHBP Division.** You are responsible for reading any information SHBP, BCBSGa, Unitedhealthcare of Georgia, Kaiser Permanente, Healthways, or ESI send to you at this address. If you are not able to review Plan information for any reason, it is your responsibility to designate a representative to act on your behalf.
- **Notify us if you have a qualifying event that can affect coverage or eligibility for coverage for you or a Covered Dependent.** If you get married, divorced or have a baby, you may want to add or delete a dependent. You must notify your payroll location within 31 days (45 days for a newborn) of the event – or you won't be able to make the change until the next Open Enrollment period. Retirees do not have an Open Enrollment period; failure to notify the Plan within 31 days of a qualified change in status (45 days for a newborn) could permanently prohibit a retiree from making the desired change.
- **Furnish the DCH, SHBP Division with information required to implement Plan provisions**. When you are required to provide certain information and documentation, failure to do so by the deadline will result in denial of requested coverage. No claims will be paid until the documentation is received and approved by DCH, SHBP Division.
- **Update the DCH, SHBP Division on the status of eligible dependents.** If your dependent child is nearing age 26, and is eligible to continue coverage as a disabled dependent you are responsible for informing the Plan of his or her status within 31 days of reaching age 26. Coverage won't continue automatically after a disabled dependent turns 26 – you must request it.
- **Notify the DCH, SHBP Division of any other group coverage you have,** including Medicare coverage. You may be required to provide notification in advance or on request.

Your Employer's Responsibilities

Your employer – your department, agency or other entity – has specific responsibilities under the Plan, which includes the following:

- Properly notifying the Plan Administrator for your employment classification.
- Timely paying all required employer contribution.
- Submit any necessary documentation in a timely and efficient manner.
- Withhold proper monthly premiums and submit them, along with the bill to the Plan when due. If your employer does not send in premiums and documentation in a proper and timely manner, the Plan may suspend coverage benefit payments for the Employee.
- Assist in enrolling all eligible employees in the Plan within 31 days of hire unless the employee declines coverage. Then the declination form must be completed within 31 days of hire.
- Provide enrollment information to the Plan Administrator.
- Distribute Plan materials
- Administer the Family and Medical Leave Act (FMLA) in compliance with federal law.
- Administer Military Leave in compliance with federal law.
- Administer Leave without Pay for employees.
- Collect all required premiums for employees on unpaid leave.
- 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) days of the return to working.
- Provide you with information on how you can continue coverage under the FMLA and under state leave without pay provisions.
- Provide necessary termination of coverage information to the Plan Administrator within 30 days after your employment ends or your eligibility for Plan Membership ends.
- Notify enrolled employees of Plan amendments or termination.
- Notify enrolled employees of the employer's decision to stop offering SHBP coverage to all or some of its employees.

Assistance with Your Questions

If you have any questions about your rights and responsibilities under this Plan, you should contact the Plan's Member Services Center at: 1-800-610-1863.

Former Employee and Annuitant Rights and Responsibilities

Your Rights as a Former Employee and Annuitant Enrolled in Plan Coverage

As a Former Employee and Annuitant enrolled in Plan coverage, you have the right to:

- Have your eligible claims paid and notifications provided in a timely manner
- Receive information about the Plan and the options available to you
- Be informed of the process for filing appeals of denied claims
- Have access to Provider information
- Review your appeal file
- Examine, without charge, all documents governing the Plan at the Plan Administrator's office
- Request copies of the above documents, in writing, from the Plan Administrator (a reasonable copy fee may apply)
- Be informed by the Plan of how to continue your coverage if it would otherwise end in certain situations

Your Rights for Continuing Group Health Plan Coverage

You have the right to continue group health plan coverage if you lose Plan coverage due to a qualifying event. In this case, you may continue health care coverage for yourself, spouse or dependents; however, you or your dependents may have to pay for such coverage. Review this Eligibility Document and other Plan documents governing your continuation coverage rights.

Your Responsibilities as a Former Employee or Annuitant Enrolled in Plan Coverage

As a former employee or annuitant enrolled in Plan coverage, you can receive the most value from your coverage if you fulfill the following responsibilities:

- **Make proper and timely premium payments.** Premium payments usually are made through 1) the state retirement system for retirees who receive an annuity or 2) by paying directly to SHBP. Coverage must be continuous. If payment is not made for coverage each month, coverage will be terminated with no right to reinstatement.
- **Take the time to understand how the Plan option works.** You are the manager of your health care needs and, therefore, you must take the time to understand your Plan option. You also are responsible for understanding the consequences of your decisions. Carefully review this booklet and the *Retiree Health Plan Decision Guide.* Having read the documents, you can take steps to maximize your coverage.

- **Answer surcharge questions truthfully and notify DCH, SHBP Division immediately if the answers to your surcharge questions change during the year.** Intentional misrepresentation in response to surcharge questions or failure to notify DCH, SHBP Division of changes to your responses to surcharge will have significant consequences. Former employees and annuitants who intentionally misrepresent the response to the surcharge questions or fail to notify DCH, SHBP Division of changes to their responses will permanently lose their SHBP health insurance.
- **Notify DCH, SHBP Division if you or any of your dependents are no longer eligible for coverage.** If you misrepresent eligibility information when applying for coverage, during a change in coverage or when filing for benefits, or by paying for coverage on behalf of someone who is not eligible, adverse action may be taken against you by DCH or applicable enforcement agencies. Adverse actions include, but are not limited to: terminating your coverage, collection actions for all payments improperly made as a result of the misrepresentation, and criminal prosecution.
- **Notify DCH, SHBP Division of any address change and read all information sent to you by DCH, SHBP Division.** You are responsible for reading any information we or any Claims Administrator send to you at this address. If you are not able to review Plan information for any reason, it is your responsibility to designate a representative to act on your behalf
- **Notify DCH, SHBP Division if you have a qualifying event that can affect coverage or eligibility for coverage for you or a Covered Dependent.** If you get married, divorced or have a baby, you may want to add or delete a dependent. Former employees and annuitants do not have an Open Enrollment period; failure to notify DCH, SHBP Division within 31 days (45 days for a newborn) of a qualified change in status could permanently prohibit a former employee or annuitant from making the desired change.
- **Furnish DCH, SHBP Division with information required to implement Plan provisions**. When you are required to provide certain information and documentation, failure to do so by the deadline will result in denial of requested coverage.
- **Notify the DCH, SHBP Division of any other group coverage you have,** including Medicare coverage. You may be required to provide notification in advance or on request.

Assistance with Your Questions

If you have any questions about your rights and responsibilities under this Plan, you should contact the Plan's Member Services Center at 1-800-610-1863.

Section 1.7:
Glossary of Defined Terms

This section:
- Defines the terms used in this Eligibility & Enrollment document
- Is not intended to describe benefits.

Annual Enrollment Period - a period of time that follows the Initial Enrollment Period during which Eligible Persons who are Active Employees may enroll themselves and Dependents under the Plan, as determined by the DCH, SHBP Division.

Annuity – is the monthly retirement check that an individual receives who has met the requirements of a state sponsored Retirement System.

Annuitant – an individual who is enrolled in the Plan at the time he/she retires and is immediately eligible to draw a retirement annuity from a State of Georgia sponsored Retirement Systems.

Annuitant Premiums – is the health premium that is deducted from the retirement check that retirees who are enrolled in the Plan and are drawing a retirement annuity from a State of Georgia sponsored Retirement Systems. Currently this premium is the same as an active employee

Covered Person - either the Enrolled Member or an Enrolled Dependent, but this term applies only while the person is enrolled under the Plan. References to "you" and "your" throughout this Eligibility Document are references to a Covered Person.

Dependent – a person who meets all dependent eligibility requirements as a result of his/her relationship with an Enrolled Member.

Direct Pay – is the monthly premium individuals who meet the eligibility requirements to continue coverage and pay directly to SHBP (8+ years of service or more). Premiums must be paid directly to DCH/SHBP Division when continuing health insurance after active employment ends.

Enrolled Member – a person who meets all eligibility requirements for the Plan as a result of his/.her current or former employment, who is currently enrolled in Coverage and who has paid he necessary contribution or premium for such Coverage in the manner required by the Plan Administrator.

Health Reimbursement Arrangement Account (HRA) – means an account set up on behalf of the Employee in accordance with applicable Internal Revenue Code requirements, under which expenses associated with Covered Services for which Claims have been submitted under any of the plan options are reimbursed. The HRA accounts generally are integrated with the applicable plan option, but there may be instances in which a standalone HRA exists as the result of a residual HRA balance upon termination of coverage under a plan option

Medical Claims Administrator - the company (including its affiliates) that provides certain claim administration services for the Plan. See the Introduction for the Claims Administrators that have been engaged for each component of this Plan.

Medical Management Administrator - means the entity with whom DCH has contracted to provide medical management services. Medical management services include but are not limited to Case Management, 24 Hour Nurse Line, Disease Management, Behavioral Health Management, and Utilization Management.

Pharmacy Benefits Administrator – means the entity with whom DCH has contracted to administer prescription drug benefits.

Plan - the State Health Benefit Plan.

Plan Administrator - Georgia Department of Community Health, SHBP Division.

Plan Sponsor - Georgia Department of Community Health.

Qualified Medical Child Support Order (QMCSO) – Any judgment, decree order (including approval of a settlement agreement), or National Medical Support Notice that a court of competent jurisdiction or a state agency issues and is approved by the DCH, SHBP Division as a qualified medical child support order or National Medical Support Notice. The order must provide for medical coverage for your child.

Retiree and Retiree Coverage – Former employees who have continued SHBP coverage by paying the premiums required for annuitants (currently, the same cost as active premiums) or for former employees with eight or more Years of Service (currently the full cost of coverage) are referred to in this Eligibility Document as "retirees." All

Retiree Option Change Period – A period during which former employees enrolled in SHBP coverage may select a new coverage option. A former employee who discontinued SHBP coverage to enroll in TRICARE supplemental coverage may re-enroll in SHBP coverage during the Retiree Option Change Period as long as he or she maintained continuous coverage under either SHBP or TRICARE supplemental coverage.

State Health Benefit Plan (SHBP) – The State Health Benefit Plan is comprised of three health insurance plans established by Georgia law: 1) a plan for State employees (O.C.G.A. § 45-18-2), 2) a plan for teachers (O.C.G.A. § 20-2-891), and 3) a plan for non- certificated public school employees (O.C.G.A. § 20-2-911). Currently, benefit options are the same under all three plans and they are usually referred to together as the State Health Benefit Plan. This HDHP Option is an option under the State Health Benefit Plan.

Split Eligibility – when one person or more is under age 65 and one person or more than 65 or older with Medicare Part B. The under 65 individuals are covered by a non-MA option and the 65+ individuals are enrolled in a MA option.

State Extended Coverage – is the continuation of health insurance by an individual who will qualify for a retirement annuity but does not qualify for an immediate annuity due to age from a State of Georgia sponsored Retirement Systems.

State Extended Coverage Premium - is the monthly premium individuals who meet the eligibility requirements to continue coverage and pay directly to SHBP (8+ Years of Service or more). Premiums must be paid directly to DCH, SHBP Division when continuing health insurance after active employment ends prior to receiving an annuity.

references to Retiree Coverage apply to coverage in the SHBP as a former employee or annuitant.

State Retirement Systems

Below are the list of State Retirement Systems

- Employees' Retirement System (ERS)
- Teachers Retirement System (TRS)
- Public School Employees Retirement System (PSERS)
- Local School System Teachers Retirement Systems
- Fulton County Retirement System (eligible Members)
- Legislative Retirement System
- Superior Court Judges or District Attorney's Retirement System

Wellness Program Administrator – means an entity with which DCH has contracted to provide wellness and prevention programs.

Years of Service – Years of Service means years of service credited under the following State Retirement Systems:

- Employees' Retirement System (ERS)
- Teachers Retirement System (TRS)
- Public School Employees Retirement System (PSERS)
    - Local School System Teachers Retirement Systems
    - Fulton County Retirement System (eligible Members)
    - Legislative Retirement System

- Superior Court Judges or District Attorney's Retirement System

Section 1.8:
Legal Notices

This section provides state and federal mandated legal notices

TRICARE Supplement for Eligible Military Members

Federal Patient Protection and Affordable Care Act Notices

- Choice of Primary Care Physician
- Access to Obstetrical and Gynecological (ObGYN) Care
- Special Enrollment Notice
- Women's Health and Cancer Rights Act of 1998
- Statement of Rights under the Newborns' and Mothers' Health Protection Act
- Patient Protection and Affordable Care Act ("PPACA")
- Michelle's Law

TRICARE Supplement for Eligible Military Members

The TRICARE Supplement Plan is an alternative to SHBP coverage that is offered to employees and dependents that are eligible for SHBP coverage and enrolled in TRICARE. The TRICARE Supplement Plan is not sponsored by the SHBP, the Department of Community Health or any employer. The TRICARE Supplement Plan is sponsored by the American Military Retirees Association (AMRA) and is administered by the Association & Society Insurance Corporation. In general, to be eligible, the employee and dependents must each be under age 65, ineligible for Medicare and registered in the Defense Enrollment Eligibility Reporting System (DEERS).

An employee is not eligible for enrollment in TRICARE Supplement, if he/she is:

- An active duty member
- A spouse of an active duty member
- TRICARE Reserve Select Member
- A spouse of a TRICARE Reserve Select Member
- A former spouse

The TRICARE Supplement Plan works with TRICARE to pay the balance of covered medical expenses after TRICARE pays. The TRICARE Supplement Plan helps to pay 100% of members' TRICARE outpatient deductible, cost share, co-payments plus 100% of covered excess charges. Members have flexibility and freedom of choice in selecting civilian providers (physicians, specialists, hospitals and pharmacies).

If you enroll in the TRICARE Supplement and are not eligible, your election will be changed to the default option, BCBSGa Bronze, which includes the tobacco surcharge if you were paying for it prior to enrollment in the TRICARE Supplement. Your premium will be changed retroactively and the difference in premiums will be billed to the retiree. For active employees, the payroll location will be notified to take the additional premiums.

Points to Consider if You Elect TRICARE Supplement Plan Coverage

- Effective January 1, 2015, TRICARE will become your primary coverage.
- TRICARE Supplement Plan will become the secondary coverage.
- The eligibility rules and benefits described in the TRICARE Supplement Plan will apply
  - Unmarried adult children under the age of 26 who are no longer eligible for regular TRICARE must be enrolled in TRICARE Young Adult (TYA) through TRICARE before enrolling in the TRICARE Supplement Plan.
  - Unmarried children under the age of 21 or 23 if a full-time student who are no longer eligible for regular TRICARE must be enrolled in TRICARE Young Adult (TYA) through TRICARE before enrolling in the TRICARE Supplement Plan.
- Tobacco Surcharge will not apply.
- COBRA rights will not apply.

If you or your dependents lose eligibility for SHBP coverage while you are enrolled in the TRICARE Supplement Plan, you will be offered a portability feature by the Association & Society Insurance Corporation (ASI), administrator of TRICARE Supplement.

- Loss of eligibility for the TRICARE Supplement Plan is a qualifying event. If you continue to be eligible for coverage under the SHBP, you may enroll in an SHBP Option outside of the Open Enrollment period if you make a request within 31 days of losing eligibility for the TRICARE Supplement Plan.
- Attainment of age 65 and eligibility for Medicare causes a loss of eligibility for TRICARE Supplement Plan coverage. This is a qualifying event and retirees must make a request within 31 days in order to re-enroll in an SHBP coverage option.
- Retirees who elect TRICARE Supplement Plan coverage may change to another option during Retiree Option Change Period as long as they maintain continuous coverage through SHBP.

For complete information about eligibility and benefits, contact **866-637-9911** or visit **www.asicorporation.com/ga_shbp**. You may also find information at **www.dch.georgia.gov/shbp**.

FEDERAL PATIENT PROTECTION AND AFFORDABLE CARE ACT NOTICES

Choice of Primary Care Physician

The Plan generally allows the designation of a Primary Care Physician (PCP). You have the right to designate any PCP who participates in the Claims Administrator's network, and who is available to accept you or your family Members. For information on how to select a PCP, and for a list of PCP's, contact the telephone number on the back of your Identification Card or refer to the Claims Administrator's website at: www.bcbsga.com/shbp. For children, you may designate a pediatrician as the PCP.

Access to Obstetrical and Gynecological (ObGyn) Care

You do not need Prior Authorization from the Plan or from any other person (including a PCP) in order to obtain access to obstetrical or gynecological care from a health care professional in the Claims Administrator's network who specializes in obstetrics or gynecology.. The health care professional, however, may be required to comply with certain procedures, including obtaining Prior Authorization for certain services or following a pre-approved treatment plan. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the telephone number on the back of your Identification Card; or refer to the Claims Administrator's website at: www.bcbsga.com/shbp**.**

Special Enrollment Notice

If you are declining enrollment for yourself, or your Dependents (including your spouse) because of other health insurance coverage, you will be able to enroll yourself and your Dependents. However, you must request enrollment within 31 days after your other coverage ends.

In addition, if you have a new Dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your new Dependents. However, you must request enrollment within 31 days after the marriage, birth, adoption, or placement for adoption.

Eligible Covered Persons and Dependents may also enroll under two additional circumstances:

- The Covered Person's, Dependent's Medicaid or Children's Health Insurance Program (CHIP) coverage is terminated as a result of loss of eligibility; or
- The Covered Person or Dependent becomes eligible for a subsidy (State Premium Assistance Program).

The Covered Person or Dependent must request Special Enrollment within 60 days of the loss of Medicaid/CHIP or of the eligibility determination. **To request Special Enrollment or obtain more information, call the Customer Service telephone number on the back of your Identification Card, or contact your Benefit Coordinator/Payroll Location.**

Women's Health and Cancer Rights Act of 1998

The Plan complies with the Women's Health and Cancer Rights Act of 1998. Mastectomy, including reconstructive surgery, is covered the same as other surgery under your Plan option. Following cancer surgery, the SHBP covers:

- All stages of reconstruction of the breast on which the mastectomy has been performed
- Reconstruction of the other breast to achieve a symmetrical appearance
- Prostheses and mastectomy bras
- Treatment of physical complications of mastectomy, including lymphedema

NOTE: Reconstructive surgery requires prior approval, and all Inpatient admissions require prior notification.

For more detailed information on the mastectomy-related Benefits available under the Plan, you can contact the Member Services unit for your coverage option. Telephone numbers are on the inside front cover of the Decision Guide.

Statement of Rights under the Newborns' and Mothers' Health Protection Act

The Plan complies with the Newborns' and Mothers' Health Protection Act of 1996. Group health plans and health insurance issuers generally may not, under federal law, restrict Benefits for any Hospital length of stay in connection with childbirth for the mother or newborn to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending Provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a Provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Patient Protection and Affordable Care Act ("PPACA")

Patient Protection Notices

The Medical Claims Administrator generally allows the designation of a Primary Care Provider. You have the right to designate any Primary Care Provider who participates in the Medical Claims Administrator's network and who is available to accept you or your family Members. For information on how to select a Primary Care Provider, and for a list of the participating Primary Care Providers, contact the Medical Claims Administrator at the toll-free number on the back of your ID card. For children, you may designate a pediatrician as the Primary Care Provider.

You do not need Prior Authorization from the Medical Claims Administrator or from any other person (including a Primary Care Provider) in order to obtain access to obstetrical or gynecological care from a health care professional in the Medical Claims Administrator's network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining Prior Authorization for certain services, following a pre-approved treatment plan, or procedures for making Referrals.

Michelle's Law

This Plan complies with Michelle's Law (PHSA §2722(A)(2)(e). Michelle's Law allows a seriously ill or injured dependent child (up to age 26) of an Eligible Member.