



GEORGIA DEPARTMENT OF COMMUNITY HEALTH ANNUAL LEGAL NOTICES (No Action Required)

Women's Health and Cancer Rights Act

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.

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

SHBP complies with the Statement of Rights under the Newborns' and Mothers' Health Protection Act.

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)._

Health Insurance Portability and Accountability Act (HIPAA) Annual Notice

This section describes certain rights available to you under the Health Insurance Portability and Accountability Act (HIPAA) when you add a dependent to your State Health Benefit Plan (SHBP) coverage.

The PPO, PPO CCO and Indemnity Options contain a pre-existing condition (PEC) limitation. Specifically, the Health Plan will not pay charges that are over \$1,000 for the treatment of any pre-existing condition during the first 12 months of a patient's coverage, unless the patient gives satisfactory documentation that he or she has been free of treatment or medication for that condition for at least six consecutive calendar months. However, a PEC limitation does not apply to coverage for:

- Pregnancy; or
- Newborns or children under age 18 who are adopted or placed for adoption, if the child becomes covered within 31 days after birth, adoption or placement for adoption

In certain situations, SHBP members and dependents can reduce the 12-month PEC limitation period. The reduction is possible by using what is called "creditable coverage" to offset a PEC period. Creditable coverage generally includes the health coverage you or a family member had immediately prior to joining the SHBP. Coverage under most group health plans, as well as coverage under individual health policies and governmental health programs, qualifies as creditable coverage.

To reduce the PEC limitation period for your own coverage, you must provide the SHBP with a certificate of creditable coverage from one or more former health plans or insurers that states when your prior coverage started and ended. Any period of prior coverage will reduce the 12-month limitation period if the time between losing coverage and the first day of your SHBP coverage does not exceed 63 days. If you are enrolling as a new hire, the 63-day period is measured from your last day of prior coverage up to your date of hire.

To reduce the PEC limitation period for your dependents (including your spouse), you must provide the SHBP with a certificate of creditable coverage stating when coverage started and ended for each dependent that you want to cover. Any period of prior coverage for that dependent will reduce the 12-month limitation period if no more than 63 days have elapsed between the dependent's loss of prior coverage and the first day of coverage under the SHBP (or your date of hire, if you are enrolling as a new hire).

If you or your dependent (including a spouse) had any break in coverage lasting more than 63 days, you or your dependent will receive creditable coverage only for the period of time after the break ended.

Within two years after your former coverage terminated, you have the right to obtain a certificate of creditable coverage from your employer(s) to offset the pre-existing condition limitation period under the SHBP. The SHBP will evaluate the certificate of creditable coverage or other documentation to determine whether any of the pre-existing condition limitation period will be reduced or eliminated. After completing the evaluation, the SHBP will notify you as to how the pre-existing condition limitation period will be reduced or eliminated. Please submit the certificate of creditable coverage to the Plan with your enrollment paperwork. If you require assistance in obtaining a letter from a former employer, contact your personnel/payroll office.

July 7, 2008

TO: All Members of the State Health Benefit Plan

Under a federal law known as the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”), certain notices must be provided to you. This letter will serve as notice to you related to the surcharge for tobacco use that the Plan will charge for coverage January 1, 2009. This memo will also serve as notice to you that the State Health Benefit Plan, (“SHBP”) has elected to exempt SHBP from the Special enrollment periods.

Under HIPAA, group health plans may not discriminate on the basis of “health status.” However, the law also permits state and local government employers that sponsor health plans to elect to exempt a plan from this requirement for any plan that is “self-funded” by the employer, rather than provided through a private health insurance policy. The Department of Health and Human Resources considers tobacco use to be a “health status.” Therefore, the self-funded options under the SHBP have opted out of this requirement for the plan year January 1, 2009 through December 31, 2009. The election may be renewed for subsequent plan years. The purpose of this exemption is to enable the SHBP to comply with federal law in applying the tobacco use surcharge.

Therefore, this notice informs all members of the self-funded options of the SHBP of the Plan’s election to be exempt from the following provision:

Prohibitions against discriminating against individual participants and beneficiaries based upon health status. A group health plan may not discriminate in enrollment rules or in the amount of premiums or contributions; it requires an individual to pay based on certain health status-related factors: health status, medical condition (physical and mental illnesses), claims experience, receipt of health care, medical history, genetic information, evidence of insurability, and disability.

The exemption and this notice to not change your eligibility, your benefits, or your premiums, other than to apply the surcharge for tobacco use, if applicable.

HIPAA also requires the Plan to provide covered employees and dependents with a “certificate of creditable coverage” when they cease to be covered under the Plan. There is no exemption from this requirement. The certificate provides evidence that you were covered under this Plan because you may be entitled to certain rights to reduce or eliminate a preexisting condition exclusion if you join another employer’s health plan, or if you wish to purchase an individual health insurance policy. You may obtain the certificate of creditable coverage upon request.

The SHBP elects to be exempt from Special enrollment periods. Group health plans are required to provide special enrollment periods for individuals who do not enroll in the plan because they have other coverage, but subsequently lose that coverage. Also, if a plan provides dependent coverage, the plan must provide a special enrollment for new dependents (and the employee is not already enrolled) within 30 days after a marriage birth, adoption or placement for adoption. As a self-funded non-federal governmental group health plan, the SHBP of the Georgia Department of Community Health (“DCH”) elects to opt-out of this option.

If you have any questions about this notice, you may contact: State Health Benefit Plan, Attn: Surcharge, P. O. Box 38342, Atlanta, GA 30334.

Department of Community Health Privacy Notice

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

The Plan's Privacy Commitment to You

The Georgia Department of Community Health (DCH) understands that information about you and your family is personal. DCH is committed to protecting your information. This notice tells you how DCH uses and discloses information about you. It tells you your rights and the Plan's requirements about your information.

Understanding the Type of Information that the Plan Has

Your employer (state agency, school system authority, etc.) sent information about you to DCH. This information included your name, address, birth date, phone number, Social Security Number, gender and other health insurance policies that you may have. It may also have included health information. When your health care providers send claims to the Plan's claims administrator for payment, the claims include your diagnoses and the medical treatments you received. For some medical treatments, your health care providers send additional medical information to the Plan such as doctor's statements, x-rays or lab test results.

Your Health Information Rights

You have the following rights regarding the health information that DCH has about you:

- You have the right to see and obtain a copy of your health information. An exception is psychotherapy notes. Another exception is information that is needed for a legal action relating to DCH
 - You have the right to ask DCH to change health information that is incorrect or incomplete. DCH may deny your request under certain circumstances
 - You have the right to request a list of the disclosures that DCH has made of your health information beginning in April 2003
 - You have the right to request a restriction on certain uses or disclosures of your health information. DCH is not required to agree with your request
 - You have the right to request that DCH communicates with you about your health in a way or at a location that will help you keep your information confidential
 - You have the right to receive a paper copy of this notice. You may ask DCH staff to give you another copy of this notice, or you may obtain a copy from DCH's Web site, www.dch.georgia.gov. Click on HIPAA Privacy Notices.
-

Privacy Law's Requirements

DCH is required by law to:

- Maintain the privacy of your information
- Give you this notice of DCH's legal duties and privacy practices regarding the information that DCH has about you
- Follow the terms of this notice.
- Not use or disclose any information about you without your written permission, except for the reasons given in this notice. You may take away your permission at any time, in writing, except for the information that DCH disclosed before you stopped your permission. If you cannot give your permission due to an emergency, DCH may release the information if it is in your best interest. DCH must notify you as soon as possible after releasing the information.

In the future, DCH may change its privacy practices. If its privacy practices change significantly, DCH will provide a new notice to you. DCH will post the new notice on its Web site at www.dch.georgia.gov. Click on HIPAA Privacy Notices. This notice is effective April 14, 2003.

How DCH Uses and Discloses Health Care Information

There are some services the Plan provides through contracts with private companies. For example, a health insurance company pays most medical claims to your healthcare providers. When services are contracted, the Plan may disclose some or all of your information to the company so that they can perform the job the Plan has asked them to do. To protect your information, the Plan requires the company to safeguard your information in accordance with the law.

The following categories describe different ways that the Plan uses and discloses your health information. For each category, we will explain what we mean and give an example.

For Payment

The Plan may use and disclose information about you so that it can authorize payment for the health services that you received. For example, when you receive a service covered by the Plan, your healthcare provider sends a claim for payment to the claims administrator. The claim includes information that identifies you, as well as your diagnoses and treatments.

For Medical Treatment

The Plan may use or disclose information about you to ensure that you receive necessary medical treatment and services. For example, if you participate in a Disease State Management Program, the Plan may send you information about your condition.

To Operate Various Plan Programs

The Plan may use or disclose information about you to run various Plan programs and ensure that you receive quality care. For example, the Plan may contract with a company that reviews hospital records to check on the quality of care that you received and the outcome of your care.

To Other Government Agencies Providing Benefits or Services

The Plan may give information about you to other government agencies that are giving you benefits or services. The information must be necessary for you to receive those benefits or services and will be authorized by you or by law.

To Keep You Informed

The Plan may mail you information about your health and well-being. Examples are information about managing a disease that you have, information about your managed care choices, and information about prescription drugs you are taking.

For Overseeing Health Care Providers

The Plan may disclose information about you to the government agencies that license and inspect medical facilities, such as hospitals, as required by law.

For Research

The Plan may disclose information about you for a research project that has been approved by a review board. The review board must review the research project and its rules to ensure the privacy of your information. The research must be for the purpose of helping the Plan.

As Required by Law

The Plan will disclose information about you as required by law.

Under the HIPAA Privacy Law, you may authorize the Plan to release your Personal Health Information (PHI) to another individual. If you have authorized the release of PHI to another individual, the personal representative form authorizing the release of your PHI is not transferred between options. This is for the protection of your privacy. If you wish to continue to designate another individual after changing health options, you may be asked to complete a new personal representative form.

For More Information or to Report a Problem

If you have questions and would like additional information, you may contact the SHBP at 404-656-6322 (Atlanta calling area) or 800-610-1863 (outside of Atlanta calling area).

If you believe your privacy rights have been violated:

- You can file a complaint with the Plan by calling the SHBP at 404-656-6322 (Atlanta calling area) or 800-610-1863 (outside of Atlanta calling area), or by writing to: SHBP–HPU, P.O. Box 38342, Atlanta, GA 30334
- You can file a complaint with the Health and Human Services Office for Civil Rights by writing to: U.S. Department of Health and Human Services Office for Civil Rights, Region IV, Atlanta Federal Center, 61 Forsyth Street SW, Suite 3B70, Atlanta, GA 30303-8909. Phone 404-562-7886; Fax 404-562-7881; TDD 404-562-7884, www.hhs.gov/ocr

There will be no retaliation for filing a complaint.