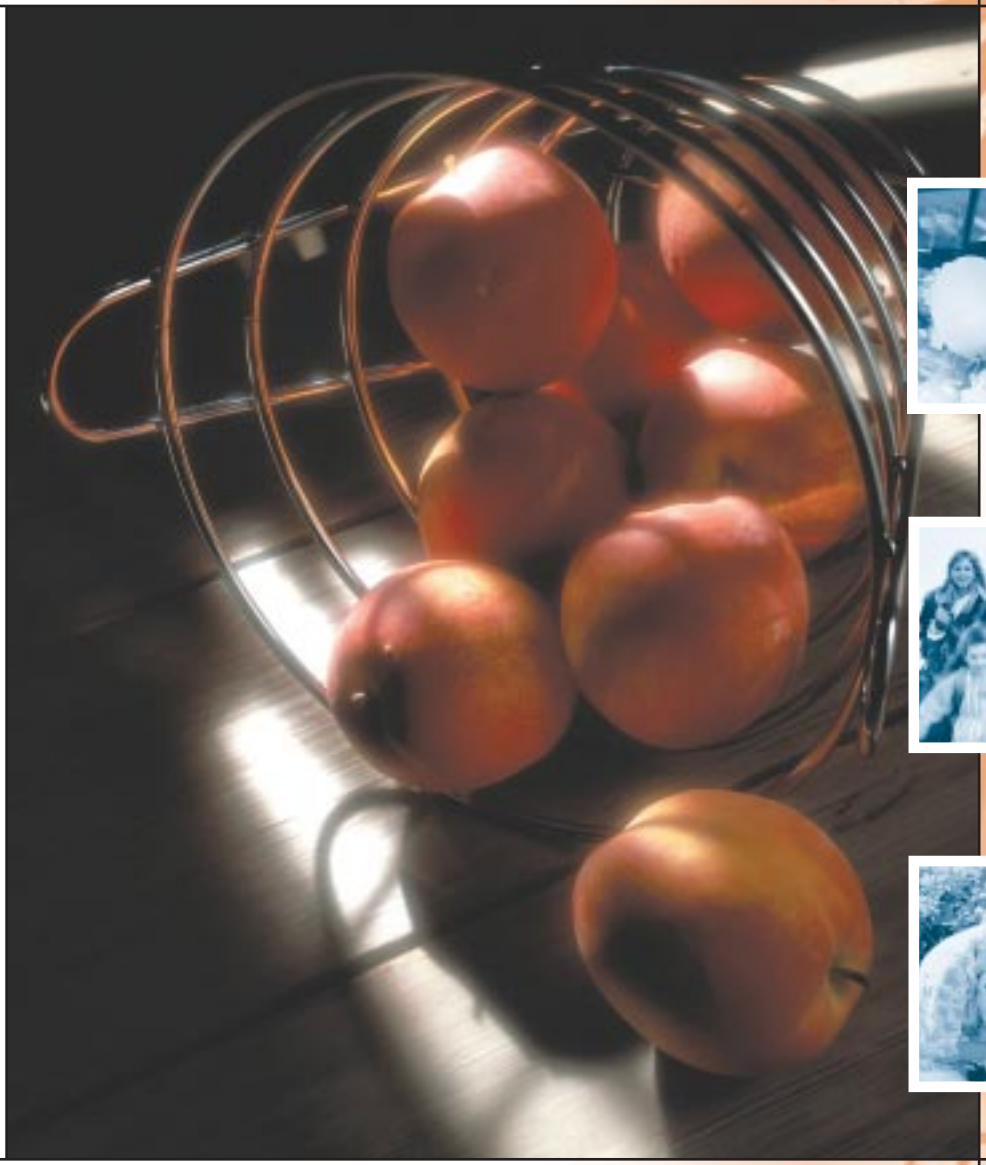
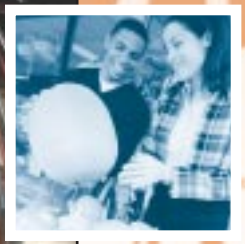
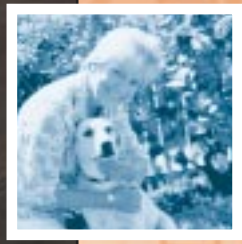
Georgia Department of Community Health
Division of Public Employee Health Benefits







STATE HEALTH BENEFIT PLAN

HEALTH PLAN DECISION GUIDE

FOR RETIREES

JULY 1, 2002 – JUNE 30, 2003

PREFERRED PROVIDER ORGANIZATION (PPO) OPTIONS

INDEMNITY OPTION

HEALTH MAINTENANCE ORGANIZATION (HMO) OPTIONS

PHONE NUMBERS AND CONTACTS FOR BENEFIT AND PROVIDER INFORMATION

Georgia Department of Community Health
Retiree Option Change Period for 2002 – 2003
April 15 – May 14, 2002

Check www.statehealth.org to make coverage changes online during the Retiree Option Change Period. Or complete and return your Personalized Change Form (PCF) postmarked by May 14, 2002.

Benefit and Rate Information

PPO Option and PPO Choice Option

For rate and benefit coverage information, call the Retiree Help Line at (800) 586-9288

TDD line for the hearing impaired: (404) 842-8073

During the Retiree Option Change Period, call volume for these numbers is expected to be very high, and you may experience time on hold.

You can get both National and Georgia PPO provider information online at: www.healthygeorgia.com

HMOs

BlueChoice Healthcare Plan
(800) 464-1367
Online provider information:
www.bcbsga.com

CIGNA HealthCare of Georgia
(800) 564-7642
Online provider information:
www.cigna.com

Kaiser Permanente
(404) 261-2590
(800) 611-1811
Online provider information:
www.kp.org/ga

Kaiser Permanente Medicare+Choice HMO
(404) 233-3700
(800) 956-1358

UnitedHealthcare of Georgia
(866) 527-9599
Online provider information:
www.provider.uhc.com/gdch

Indemnity Option (Formerly Named High Option)

For rate and benefit coverage information, call the Retiree Help Line at (800) 586-9288

TDD line for the hearing impaired: (404) 842-8073

Prescription Drug Program Information

PPO, PPO Choice, and Indemnity Options
Contact the Pharmacy Benefit Manager, Express Scripts, at (877) 650-9342

Additional Information

Medicare or Medicare+Choice
www.medicare.gov

Centers for Medicare and Medicaid Services (CMS)
www.cms.gov

Social Security Administration
www.ssa.gov
(800) 772-1213

The information regarding Plan changes on page 5 of this Guide constitutes official notification to State Health Benefit Plan (SHBP) members of Plan changes and, as such, supersedes any previously published information that conflicts with the material included in this section of the Guide. Please keep this Guide with your Plan documents for future reference. It will be used in conjunction with the SHBP booklet dated November 1, 1995, the HMO Member Handbook dated March 1998, plus any *UPDATER* published after November 1, 1995,* to administer the Plan until new booklets are published. If you are disabled and need this information in an alternative format, call TDD Relay Service at (800) 255-0056 (text telephone) or (800) 255-0135 (voice) or write the SHBP at P.O. Box 38342, Atlanta, GA 30334.

* This is the fourteenth official Plan update published since the SHBP booklet dated November 1, 1995.

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Making Informed Health Plan Coverage Decisions

The Georgia Department of Community Health, which administers the State Health Benefit Plan (SHBP), continually seeks to bring you high-quality, affordable health coverage. Keep in mind, however, that you are the manager of your health care needs, and in turn, must take the time to understand your Plan benefit choices in order to make the best decisions for you and your family. During the Retiree Option Change Period, it is important that you carefully review the coverage option information provided in this *Retiree Health Plan Decision Guide*. You should evaluate your health care needs and, if necessary, those of your dependents, as well as the premiums and out-of-pocket costs related to these different options before making your decision. Once you make your coverage decision, you may not make changes to your coverage outside the Retiree Option Change Period unless you have a qualifying event. See page 8 for details.

If after reading this Guide you want more information before making a coverage decision, you can refer to your Summary Plan Description (SPD) booklet and *UPDATERs* or call the Retiree Help Line at (800) 586-9288.

Making informed decisions about your health care includes other considerations as well. Patient safety is a critical mission for the SHBP. Therefore, we offer these five steps to safer health care:

1. **Speak up if you have questions or concerns.** Choose a physician whom you feel comfortable talking to about your health and treatment. Take a relative or friend with you if this will help you ask questions and understand the answers. It's okay to ask questions and to expect answers you can understand.
   - If you are considering PPO coverage, provider directories are available to help you choose physicians who have been credentialed in their specialties. Visit the MRN/Georgia 1st Web site at www.healthygeorgia.com for the most up-to-date listing of over 12,000 physicians and 170 hospitals in Georgia and a link to national PPO provider information for national access to 580,000 physicians and 3,400 hospitals. Printed directories are available by calling the Retiree Help Line during the Retiree Option Change Period.
   - If you are considering HMO coverage, see the inside front cover for HMO Web sites that include provider information. You also can contact the individual HMO directly to request a provider directory.

   However, the provider listings are subject to change without notice. Before selecting your physician, call the physician's office to make sure that physician is accepting new patients and that he/she is still a participating provider.
2. **Keep a list of all the medicines you take.** Tell your physician and pharmacist about the medicines that you take, including over-the-counter medicines such as aspirin, ibuprofen, and dietary supplements like vitamins and herbals. Tell them about any drug allergies you have. Ask the pharmacist about side effects and what foods or other things to avoid while taking the medicine. When you get your medicine, read the label, including warnings. Make sure it is what your physician ordered, and you know how to use it. If the medicine looks different than you expected, ask the pharmacist about it.
3. **Make sure you get the results of any test or procedure.** Ask your physician or nurse when and how you will get the results of tests or procedures. If you do not get them when expected—in person, on the phone, or in the mail—don't assume the results are fine. Call your physician and ask for them. Ask what the results mean for your care.

4. **Talk with your physician and health care team about your options if you need hospital care.**
   If you have more than one hospital to choose from, ask your physician which one has the best care and results for your condition. Hospitals do a good job of treating a wide range of problems. However, for some procedures (such as heart bypass surgery), research shows results often are better at hospitals doing a lot of these procedures. Also, before you leave the hospital, be sure to ask about follow-up care, and be sure you understand the instructions.

5. **Make sure you understand what will happen if you need surgery.**
   Ask your physician and surgeon: "Who will take charge of my care while I'm in the hospital? Exactly what will you be doing? How long will it take? What will happen after the surgery? How can I expect to feel during recovery?" Tell the surgeon, anesthesiologist, and nurses if you have allergies or have ever had a bad reaction to anesthesia. Make sure you, your physician, and your surgeon all agree on exactly what will be done during the operation.

Provider Directories:

For PPO providers

Visit the MRN/Georgia 1st Web site at www.healthygeorgia.com for the most up-to-date listing of Georgia PPO providers. This Web site also has a link to a listing of National PPO (Beech Street) providers located across the United States. You also can call the Retiree Help Line at (800) 586-9288 to request printed provider directories.

For HMO providers

Check the HMO's Web site for current providers or call to request a current HMO directory. Note: If you sign up for one of the HMO options, receipt of your HMO card could be delayed if a primary care physician selection is not received by the HMO. Be sure to select a primary care physician if you enroll online, or indicate your selection on your Personalized Change Form if you are mailing the information to the Health Plan. *Note: If you select UnitedHealthcare HMO, you do not need to select a primary care physician.*

What You Need to Do

1 **Review The Materials In Your Package**

Review this Guide and your Personalized Change Form (PCF). Keep your PCF, which has your mailing address on the back. Be sure to read the *What's Changing for 2002 – 2003* section on page 5 for important information about Plan changes and new HMOs.

If you need to correct your address, you can do this by indicating your new address on your PCF. If there are other corrections needed, call the Plan's Eligibility Unit at (800) 610-1863, or in the Atlanta area (404) 656-6322.

2 **If No Changes Are Needed**

To continue your current coverage for 2002 – 2003:

➤➤➤ **PPO and Indemnity Options (Formerly Named Standard PPO and High Options)**

You do not need to take any action. Your coverage will be continued at the new costs shown on your Personalized Change Form. This also applies to any currently covered family members.

➤➤➤ **HMO and Medicare+Choice HMO Options**

Refer to the HMO Options charts starting on page 35 of this Guide to see if your current HMO is still available in your area. If so, and you do nothing, your current coverage will be continued automatically. If the HMO is no longer available, and you do nothing, your coverage will be transferred automatically to the PPO Option.

3 **To Change Your Coverage**

- Online: Go to www.statehealth.org and access your information using your personal security code (PIN) from the upper right corner of your PCF. Instructions are on the Web site.
- By mail: Complete your PCF and mail it back to the Health Plan postmarked by the deadline, using the envelope provided in your package. Keep a copy for your records.

If you want to continue coverage for your dependents, check the appropriate box. Remember if you check "no," you won't be able to reenroll the dependent in the future unless you have a qualifying event. Note, however, that you cannot change from Family to Single coverage online.

In most cases, you and any covered family members must each select a primary care physician. You may indicate PCP selections online or on your PCF.

4 **Optional —Attend a Retiree Meeting in Your Area**

Check the list enclosed in your package for a retiree meeting scheduled in your area. You also may call the Retiree Help Line at (800) 586-9288 for information.

Confirmation of Your Change

If you make changes to your current coverage, you will receive a new ID card by mail before July 1, 2002.

If you change your coverage online, you can print a confirmation of your option change directly from the Web site or write the confirmation number that you will see on the computer screen in the space provided on your PCF for your records.

Important Note:

If you choose "No Coverage" for 2002 – 2003, you will not be able to reenroll in an SHBP option at any time in the future, unless you return to active employment with the State in a benefits-eligible position.

What's Changing for 2002-2003

First, we have changed the names of two SHBP options for the next Plan year.

- What was formerly known as the High Option will now be called the **Indemnity Option.** This is more descriptive of the type of Plan offered.
- The Standard PPO Option will be called the **PPO Option.**

Effective July 1, 2002, other changes to your Plan options include:

- **For Indemnity Option members only:**
  - ➤➤➤ An increase in the maximum out-of-pocket spending limit to $2,000 per person per Plan year with a $4,000 family maximum per Plan year.
- **For PPO Option members only:**
  - ➤➤➤ A $20 co-payment for all outpatient therapy visits will be added, subject to the applicable deductible and co-insurance payments.
  - ➤➤➤ Urgent care will be covered at 90% of the network rate, subject to the deductible, after a $35 co-payment.
- **For Indemnity and PPO Option members:**
  - ➤➤➤ Coverage of specific osseous surgeries for the treatment of periodontal disease is an out-of-network benefit. Payment is subject to the maximum Allowed Amount under the Plan, with no Balance Billing. For the PPO Option, charges are subject to the out-of-network deductible.
  - ➤➤➤ Blood products will be included as a covered inpatient/outpatient service.
  - ➤➤➤ Orthognathic surgery for children age 19 and under, born with specific craniofacial syndromes, will be a covered service.
  - ➤➤➤ Private room charges for isolation, when medically necessary, will be covered.
- Two new HMOs—CIGNA and UnitedHealthcare—will be available to you if you live in their service areas. A consumer choice option from each also will be available.
- Aetna U.S. Healthcare will not be available on or after July 1, 2002. **If you currently are in Aetna U.S. Healthcare and do not select another available option during the Retiree Option Change Period, you will be transferred automatically to the PPO Option effective July 1, 2002.**

Effective July 1, 2002, you will be required to submit official documentation to verify dependent eligibility *when requested* by the Plan.

Official documentation includes copies of certified marriage licenses for spouses, and copies of certified birth certificates, court decrees, or adoption papers for children or stepchildren.

If verification cannot be made, the dependent's coverage will be terminated retroactively to his or her coverage effective date. The Plan will make every effort allowable under the law to recover any and all payments made by the Plan on behalf of an ineligible dependent. Please read the SPD and *UPDATERs* to review dependents eligible for coverage under the Plan. A summary of eligible dependents is listed on page 7. **To avoid reimbursing the Plan for claims paid on behalf of ineligible dependents, ineligible dependents should be removed from coverage during the 2002 – 2003 Retiree Option Change Period.**

If You Do Not Make Any Changes During the Retiree Option Change Period

If you do not want to make any changes, your current coverage option and type continues into the new Plan year. However, if you are an Aetna U.S. Healthcare HMO member and you do not select another available option during the Retiree Option Change Period, your coverage will be transferred automatically to the PPO Option effective July 1, 2002.

It is not necessary to submit any paperwork if you do not want to make any changes or, for Aetna U.S. Healthcare HMO members, if you want PPO Option coverage effective July 1, 2002.

Reminder: *Please read the SPD and UPDATERs to review dependents eligible for coverage under the Plan.* ***To avoid reimbursing the Plan for claims paid on behalf of ineligible dependents, ineligible dependents should be removed during the 2002 – 2003 Retiree Option Change Period.***

If You Want to Change Your Option During the Retiree Option Change Period

The *Comparing Benefits Within Health Plan Options* section starting on page 17 of this Guide provides an overview of what services are covered by each option. Before choosing a new option, you'll probably want to look at the benefits offered and at physicians, hospitals, and other providers participating in the networks of the various options. For your reference, phone numbers for requesting provider directories and specific benefit information are listed on the inside front cover along with Web site addresses.

Knowing what your benefits cover can help prevent unexpected out-of-pocket expenses during the Plan year. Before you schedule a physician's appointment, for example, make sure you understand what services your new option covers. If you've chosen an option that offers a network of preferred providers, consider the difference between seeing in-network providers and out-of-network providers. Most out-of-network services will cost you more and are subject to balance billing.

Using the security access code on your Personalized Change Form you received in your package, you can:

- Change your address
- Change your coverage option
- Delete dependents (but you cannot change from Family to Single coverage online)
- Add or change primary care physicians for HMO Option selections
- Discontinue coverage*

* *If you choose to discontinue at any time, you will not be able to reenroll in any SHBP option in the future, unless you return to active employment in a benefits-eligible position.*

If you do not have Internet access, complete and return your Personalized Change Form to:

State Health Benefit Plan
P.O. Box 347069
Atlanta, GA 30334

The envelope must be postmarked no later than May 14, 2002. A pre-addressed return envelope is inside your package.

Note: If you sign up for one of the HMO Options, receipt of your HMO card could be delayed if the HMO does not receive your primary care physician (PCP) selection. *If you select UnitedHealthcare HMO, you do not need to select a PCP or complete the enrollment supplement form.*

REMEMBER THIS DEADLINE:

For changing your coverage during the Retiree Option Change Period — April 15 through May 14 — you can enter your changes on the Web site below, or complete and return the Personalized Change Form.

- www.statehealth.org
  8 a.m. (April 15) to 6 p.m. (May 14)
  Available 24 hours a day, 7 days a week

After sending your changes online, **be sure to obtain a confirmation number. The confirmation number is your documentation that an online transaction occurred.** Please keep this confirmation number in a safe place.

➤➤➤ **If you do not need basic information on participating in the Plan, including information on who is eligible to participate, proceed to page 17 for a comparison of benefits.**

Basic Plan Information

Eligible Dependents

A dependent is defined as:

- Your spouse, if you are legally married;
- Your never-married dependent children who are:
  1. Natural or legally adopted children and under age 19;
  2. Stepchildren under age 19 who live with you at least 180 days per year;
  3. Other children under age 19 if they live with you permanently and legally depend on you for financial support;
  4. Your natural children, legally adopted children, or stepchildren who were covered under the SHBP before age 19 and who are physically or mentally disabled and dependent on you for primary support (they may continue their existing Plan coverage past age 19); and
  5. Your children from categories 1, 2, or 3 above who are registered full-time students at fully accredited schools, are not employed full-time, and are between the ages of 19 and 25.

Documentation Upon Request

In order to cover a spouse or dependent under the Plan, you must provide documentation *upon request* from the Plan. The Plan requires:

- A copy of your certified marriage license to cover spouses;
- A copy of a certified birth certificate to cover a natural child;
- A copy of a stepchild's certified birth certificate, showing your legal spouse as the natural parent of the child, and a letter documenting that your stepchild lives in your home on a permanent basis in a parent-child relationship for at least 180 days per year;
- Adoption papers, guardian or court orders for other children who live with you permanently and legally depend on you for financial support. (The SHBP will recognize and honor a Qualified Medical Child Support Order (QMCSO) for eligible dependents. See your SPD for more information);
- Disability paperwork for disabled dependents 19 and over; this documentation must be received by the Plan before the child's 19th birthday; or
- A certification letter for full-time student dependents from the registrar's office of your child's school.

In any of these situations, you may be required to provide documents to verify your dependent relationships during the Retiree Option Change Period or at various periods throughout the Plan year.

Making Changes When You Have Qualifying Events

The option choice you make during the Retiree Option Change Period will stay in effect for the duration of the 2002 – 2003 Plan year unless you have a qualifying event. Some qualifying events may allow a change to Family coverage. A change to Single coverage is allowed at any time.

Qualifying events include, but are not limited to:

- Marriage or divorce;
- Birth or adoption of a child or placement for adoption;
- Death of a spouse or child, if only dependent enrolled;
- Your spouse's or dependent's eligibility for or loss of eligibility for other group health coverage;
- A change in residence by you, your spouse, or dependents that makes you or a covered dependent ineligible for coverage in your selected option; and
- Medicare eligibility.

If you experience a qualifying event, you may be able to make changes for yourself and your dependents, provided you request those changes within 31 days of the qualifying event. For a complete description of qualifying events, see your SPD and *UPDATERs*. You can contact the Eligibility Unit for assistance at (800) 610-1863, or in the Atlanta area (404) 656-6322.

Overview of How Each Health Plan Option Works

On the following pages, you will find a brief description of each option and important considerations to help you select the best option for you. A comparison of specific benefits within each option is in the next section.

Contact the Retiree Help Line or HMO if you need more detail. Telephone numbers are on the inside front cover. You also may refer to your SPD and *UPDATERs* to obtain more details on benefits and Plan participation.

To help you understand the information in this section, a few key terms are defined below:

Important Terms to Understand

Allowed Amount—A dollar amount the Plan uses to calculate benefits payable. The Plan uses the following Allowed Amounts:

1. Network Rate—for in-network PPO services;
2. Out-of-Network Rate—for out-of-network PPO services; and
3. Indemnity Rate—for Indemnity Option services.

Balance Billing—A dollar amount charged by a provider that is over the Plan's Allowed Amount for the care received. You are subject to balance billing when you receive services from non-participating providers, including emergency services.

Co-insurance Amount—The percentage of the Plan's Allowed Amount paid by a Plan member in the PPO or Indemnity Option. Depending on the option selected, the SHBP generally pays 90% to 60%, so your co-insurance is between 10% and 40%.

Co-payment—A set dollar amount that you pay at the time you receive services or items. For example, you pay a $20 co-payment for an in-network PPO physician's office visit while you are at the physician's office. You cannot be billed later for your co-payment. Co-payments do not apply to Plan year deductibles or out-of-pocket limits unless otherwise noted.

Deductible—A specified dollar amount, which varies by Plan Option, for specified covered services that you must pay out-of-pocket each Plan year before the PPO Option or Indemnity Option pays a benefit. Depending on your coverage option, the deductible may not apply to some services. For example, the deductible does not apply to in-network physician office visits under the PPO Option. HMO Options do not have deductible.

Emergency Care—Care provided in the event of a sudden, severe, and unexpected illness or injury which, if not treated immediately, could be life-threatening or result in permanent impairment of bodily function.

Lifetime Maximum—The most you and your covered dependents may receive in benefits from the SHBP during your lifetime(s) or while you and your covered dependents are Plan members.

Medical Certification Program (MCP)—A feature of the PPO and Indemnity Options that helps you and the Plan save money by preventing unnecessary care. To receive full benefits, you must comply with the MCP requirements outlined in the SPD and *UPDATERs*.

Out-of-Pocket Limit—A maximum amount you would have to pay out of your pocket each Plan year for covered services. Once you meet your out-of-pocket limit for the Plan year, the Plan pays 100% of the Allowed Amounts for most covered services for the rest of the Plan year. Your out-of-pocket costs for premiums, co-payments, and non-covered charges are **not** applied to the limit. The deductible is applied to your annual out-of-pocket limit.

Participating Provider—Any physician, hospital, or other health-services professional or facility that offers covered services and that has joined the PPO network, the Indemnity network, or HMO network for the Plan Option. Providers nominated and accepted under a Choice Option also are considered participating providers for the person making the nomination.

PPO Option

Anyone eligible for SHBP coverage may select the PPO Option.

The PPO Option consists of a network of over 12,000 Georgia participating physicians and 170 Georgia hospitals, over 580,000 physicians and 3,400 hospitals across the United States, and hundreds of ancillary providers that have agreed to provide quality medical care and services at discounted rates. You have the choice of using in-network or out-of-network providers. If you use in-network providers, you'll receive the highest level of benefits and avoid filing claims. To view the list of Georgia PPO providers online, visit www.healthygeorgia.com.

If you choose the PPO Option, you . . .

- Can access providers in the Plan's network of over 12,000 Georgia physicians and specialists and 170 hospitals to receive a higher level of benefit coverage.
- Do not need to select a primary care physician (PCP) or obtain referrals to see specialists.
- Pay less than the Indemnity Option.
- Have no balance billing when using participating PPO providers.
- Pay only a minimal co-payment for in-network PPO physician visits, prescription drugs, and some other covered services.
- May access any licensed out-of-network physician, specialist, or hospital at any time. However, you will generally pay more for out-of-network services and charges are subject to balance billing.
- Have maximum in-network coverage for age-appropriate preventive care, including coverage for office visits.
- Have coordinated care through a vast network of providers who will assist you in receiving the maximum level of benefits.
- May have a reduced pre-existing condition limitation if you can prove creditable coverage. See the HIPAA Annual Notice on page 39 of this Guide.

National PPO Network

As a PPO Option member, you have the added benefit of access to a national network of participating providers, which is managed by the Beech Street Corporation.

You can take advantage of this national network if:

- You or a dependent lives outside of Georgia;
- You have a dependent going to school in another state;
- You are traveling in another state; or
- You want to use an out-of-state provider.

The network consists of over 580,000 physicians and 3,400 hospitals across the United States. When you access Beech Street national providers outside the Georgia service area (see page 34), you are protected from Balance Billing. Your level of benefit coverage is generally different when using the national network and you are subject to a separate deductible. To view the list of national providers online, visit www.healthygeorgia.com. If you do not have Internet access, call Member Services for provider information.

Other Points to Consider

- You must call the Medical Certification Program (MCP) to precertify inpatient stays and specified outpatient procedures when you are using out-of-network providers or Beech Street providers.
- Some physicians affiliated with a PPO may not accept new patients at some times during the year. Check with the physician of your choice before you enroll in the PPO.

See *Comparison of Benefits: PPO Option and Indemnity Option* starting on page 18 for benefit details.

PPO Choice Option

Anyone eligible for SHBP coverage may select the PPO Choice Option.

PPO Choice Option benefits are the same as in the PPO Option. However, PPO Choice Option premiums are higher. In return for a higher premium, you can request that an out-of-network provider be reimbursed as an in-network provider. This request is known as a "nomination." If the out-of-network provider accepts your nomination, agrees to the PPO fees, and is approved by the PPO, you will receive in-network benefits from that provider. The in-network relationship between you and the provider remains in effect until either you or the provider terminates the agreement. You may nominate as many eligible providers as you wish at any time during the Plan year.

If your provider does not accept your nomination, does not accept the network fees, or is not approved by the PPO, then services from that provider are covered at the lower, out-of-network benefit level. SHBP rules do not permit a member to change options when a nominated provider or the PPO rejects a nomination.

Note that you may nominate only providers located and licensed in Georgia, even if you live out of state. After the PPO receives your nomination, the PPO has three business days to either reject or approve the nomination.

For further details regarding the nomination process and to obtain the necessary paperwork, please contact the Retiree Help Line.

Note: The Behavioral Health Services (BHS) and transplant provider networks are separate from the PPO provider network. To nominate a BHS provider, contact the BHS Program at (800) 631-9943. For nominations of transplant providers, call (800) 762-4535 (outside Atlanta) or (770) 438-9770 (inside Atlanta).

Indemnity Option
(Formerly Named High Option)

Anyone eligible for SHBP coverage may select the Indemnity Option.

The Indemnity Option generally provides the same coverage level no matter which qualified medical provider you use. The Plan reimburses you for covered services, subject to the Plan's Allowed Amounts for covered services. Therefore, it is the most expensive Plan option.

The Indemnity Option has similar coverage levels when compared to in-network PPO benefits, but it has:

- A higher premium;
- Less coverage for preventive care; and
- No provider network outside of Georgia.

If you choose the Indemnity Option, you . . .

- Access any provider.
- Receive the same level of benefit coverage whether or not your provider is in the Indemnity network.
- Pay most health care bills up to the deductible amount **before** the Plan starts paying benefits.
- Continue to pay a percentage of the cost of covered expenses—co-insurance—after meeting the deductible (up to the out-of-pocket maximum) plus any non-covered costs or penalties.
- Are subject to Balance Billing in most cases.
- Receive the same level of coverage as offered in the PPO Option for prescription drug, behavioral, and transplant benefits. The Indemnity Option and PPO Option utilize the same provider networks for prescription drug, behavioral, and transplant benefits.
- Are not required to select a primary care physician (PCP) to get referrals to see specialists.
- May have a reduced pre-existing limitation if you can prove creditable coverage. See the HIPAA Annual Notice on page 39 of this Guide.

Indemnity Option (continued)

Balance Billing

You may select any provider; however, some providers have agreed to accept discounted fees with no balance billing for the Indemnity Option. Amounts that are balance billed do not count toward your deductible or out-of-pocket spending limits.

Other Points to Consider

- The Indemnity Option is the most expensive option.
- The Indemnity Option does not include a national network of providers.
- Deductible for office visits, medical care, and hospitalization must be met before benefits are payable.
- Coverage is available for preventive lab work and tests, subject to Allowed Amounts and annual maximums. Office visits for preventive care are covered, subject to the deductible and co-insurance. A co-payment-only benefit does not apply.
- Members must call the MCP to precertify in-patient stays at non-participating hospitals and members must precertify certain outpatient tests and procedures. Financial penalties apply if precertification rules are not followed.

HMO Options

HMO Options are available only to SHBP-eligible retirees who live in an HMO's approved service area. To see if you are eligible for an HMO, check pages 35 – 38 in this Guide. For the 2002 – 2003 Plan year, you may be eligible for up to five different HMO Options.

HMOs provide prepaid benefits for most health care needs, with no bills or claim forms. You choose a primary care physician (PCP) from a list of providers. You must receive care from your PCP or from a physician or facility referred by your PCP for your expenses to be covered, except in cases of emergency and in other limited cases. If you receive care from a physician other than your PCP, or without being referred by your PCP, you won't receive any benefits coverage even if the physician or facility is in the HMO network.

Note: UnitedHealthcare HMO does not require you to select a PCP or obtain referrals to specialists.

If you choose an HMO Option, you . . .

- Must access physicians, specialists, and hospitals offered through the HMO's network to receive benefits, except for emergencies.
- Choose a primary care physician (PCP) to serve as your first point of contact for most health care services. Your covered family members also must select a PCP. PCPs refer you to network providers for specialty care.
- Pay only a minimal co-payment for HMO in-network physician visits, prescription drugs, and some other covered services.
- Have coordinated care through a network of HMO participating providers.
- Have low-cost access to the many services the HMO offers in preventive health care—well-baby and well-child care, physical exams, and immunizations.

Other Points to Consider

- Generally, you don't have to file claims.
- You pay the full cost for most non-referred services and for services received outside the HMO's network, except for emergencies.
- In most cases, HMOs do not have a deductible to meet—so your out-of-pocket costs may be lower.
- There are no pre-existing condition limitations.
- You may be required to follow the HMO's standardized treatment plan for your condition. For example, you may be required to receive treatment from your primary care physician for a specified period before being referred to a specialist.

HMO Choice Options

If you are eligible for an HMO Option, you also are eligible for that HMO's Choice Option.

HMO Choice Option benefits are the same as the respective regular HMO Option benefits. However, the Choice Option premiums are higher. In return for a higher premium, the HMO Choice Option gives members the opportunity to request that an out-of-network provider be treated as an HMO network provider. This request is known as a "nomination." You may nominate providers if they are located and licensed in Georgia and offer services the HMO covers. Also, you may nominate as many eligible providers as you wish at any time during the Plan year.

If the out-of-network provider accepts your nomination, accepts the HMO's fees, and is approved by the HMO, you may receive in-network benefits from that provider. If your provider does not accept your nomination, does not accept the HMO's fees, or does not get approved by the HMO, then services from that provider are not covered. SHBP rules do not permit a member to change options when a nominated provider or the HMO rejects a nomination.

Please contact the respective HMO directly to find out more about the required procedures and paperwork necessary to nominate a provider.

Medicare+Choice HMO Option (M+C HMO)

The Medicare+Choice HMO Option is available only to those retirees who are enrolled in Part A and Part B Medicare coverage and live in the M+C HMO service area (metro Atlanta). Check page 38 in this Guide to find a listing of counties serviced by the M+C HMO.

If you choose the Kaiser M+C HMO, your new coverage will replace your Medicare coverage. Your claim forms would not be filed with Medicare and the SHBP. All your services and payments would be coordinated through the Kaiser M+C HMO.

If you choose the M+C HMO Option, you . . .

- Should refer to the information under the regular HMO Option on page 12 but also note that:
  - The Kaiser M+C provider network is different from the regular Kaiser HMO provider network.
  - If your spouse and/or dependents are not Medicare-eligible, they would automatically be enrolled in the regular Kaiser HMO. The benefits and providers available through the regular HMO are different from the M+C HMO.
- Must use providers in the Kaiser M+C HMO network in order to receive coverage. If you go outside the network, there are usually no benefits, except in the case of an emergency.
- Should return the separate form that the HMO supplies to you to ensure that you are in compliance with Medicare requirements.
- Would have coverage for prescription drugs, vision care, and preventive care not covered by Medicare.

Other Points to Consider

- You will continue to pay the Medicare Part B premium, usually deducted from your monthly Social Security benefit checks. Your coverage will be based on the rules of the M+C HMO Option, which can offer you the advantages of lower out-of-pocket costs and reduced paperwork. Medicare pays a portion of your premium directly to the M+C HMO.
- You also will pay an SHBP premium, but it will be lower than regular HMO Option premiums. See your Personalized Change Form for premium information.
- If you select the Kaiser Medicare+Choice HMO, you will receive a temporary ID card or letter to use until Medicare approves your application and you receive your permanent ID card.

If you want additional details on your Medicare benefits, contact the Social Security Administration. The phone number and Web site are listed on the inside front cover of this Guide. If you want additional details on your M+C benefits, see page 26 of this Guide and/or call the Kaiser Permanente M+C HMO at (800) 956-1358 or (404) 233-3700 in Atlanta.

How Medicare+Choice Affects Your Current Medicare Coverage

It's important to note that your benefit levels will be greater than those of regular HMOs as long as you continue to pay your Medicare Part B premiums.

Your Choice	How Medicare Works	How SHBP Benefits Work
If you choose traditional Medicare (Part A and Part B)	. . . then traditional Medicare becomes your primary plan and pays your medical benefits first	. . . and your SHBP benefits pay secondary benefits up to the Allowed Amount for Medicare Part A and Part B coverages. When Medicare is coordinated with the SHBP, you have 100% coverage on Allowed Amounts after the deductible for eligible services.
If you choose the Kaiser M+C HMO Option	. . . then traditional Medicare no longer processes your claims. Your Medicare coverage will pay a portion of the M+C HMO premium.	. . . and your SHBP benefits will pay an additional portion of your M+C HMO premium, making coverage generally less expensive than other coverage options.

Q&A on Medicare+Choice HMO and Regular HMOs

Q: What if I temporarily live outside my Medicare+Choice or regular HMO service area?

A: If you live in a different area of the country for an extended period, the M+C HMO may not be the best choice for you. Remember that services are available only within the HMO's service area, except for emergency and acute care, follow-up care, and renal-dialysis care. Call the HMO directly to request more information if needed.

Q: Can I be denied enrollment in a Medicare+Choice HMO?

A: The Centers for Medicare and Medicaid Services (CMS), responsible for the administration of Medicare, may deny your enrollment under these conditions:

- You do not reside in the service area of the M+C HMO.
- You are not entitled to Medicare Part A or are not enrolled in Medicare Part B.
- You have been diagnosed with end-stage renal disease (ESRD) or received a kidney transplant within the past 36 months (except for current HMO members). ESRD is kidney failure that requires dialysis or a transplant. However, ESRD beneficiaries currently enrolled in an HMO will be able to enroll in the M+C HMO Option. Note: If you are converting from HMO to M+C HMO coverage, you and any dependents must convert into the same HMO's M+C plan.
- If you are not approved for the Medicare+Choice HMO Option by CMS, you will be placed in the respective regular HMO Option. Your premiums will be adjusted to the regular HMO Option rates.

Q: What happens if I'm out of the HMO service area and need health care?

A: In emergencies, you should first seek treatment. Then contact your PCP as soon as practical. HMOs cover emergency care as if you were in their network. Routine (non-emergency) care or services that could have been anticipated are generally not covered outside of your HMO service area. Refer to the HMO's enrollment materials for procedures to follow.

Q: What if I'm unhappy with my primary care physician?

A: If you are unhappy, you can change to another primary care physician. The procedure will vary by HMO, so contact your HMO for assistance.

Comparing Benefits Within Health Plan Options

This section includes two charts, one that compares specific benefits within the PPO and Indemnity Options and one that compares HMO Option benefits. For more specific information on covered services, call the Member Services numbers listed on the inside front cover.

To make it easier to view information on the PPO and Indemnity Options, the chart is formatted in a "landscape" view.

SCHEDULE OF BENEFITS FOR YOU AND YOUR DEPENDENTS

July 1, 2002

COVERED SERVICES	INDEMNITY OPTION *The Plan Pays:*	PPO OPTION In-Network/Georgia *The Plan Pays:*	PPO OPTION In-Network/Out-of-State *The Plan Pays:*	PPO OPTION Out-of-Network *The Plan Pays:*
Maximum Lifetime Benefit (combined for Indemnity and PPO Option)	$2 million	$2 million		
Pre-existing Conditions; 1st year in Plan only, subject to HIPAA	$1,000	$1,000		
Lifetime Benefit Limit for Treatment of: (combined for Indemnity and PPO Option)				
• Temporomandibular joint dysfunction (TMJ)	$1,100	$1,100		
• Substance abuse	3 episodes	3 episodes		
• Organ and tissue transplants	$500,000	$500,000		
• Home hyperalimentation	$500,000	$500,000		
Deductibles/Co-payments:			In-Network/Out-of-State and Out-of-Network amounts combined	
• Deductible—individual	$300	$300	$400	
• Deductible—family maximum	$900	$900	$1,200	
• Hospital deductible/admission—excluding BHS and transplants	$100	Not applicable	Not applicable	Not applicable
• Hospital deductible/admission—BHS and transplants	$100	$100	$100	$100
• Emergency room co-payment	$60	$60	$60	$60
• Urgent care center co-payment	Not applicable	$35	$35	Not applicable

Annual Out-of-Pocket Maximums:			In-Network/Out-of-State and Out-of-Network amounts combined	
• Individual (you or one of your dependents)	$2,000	$1,000	$2,000	
• Family (you and your dependents)	$4,000	$2,000	$4,000	
• BHS program (per patient); BHS authorized care only	$2,500	$2,500		
Primary Care Physician or Specialist Office or Clinic Visits: • Treatment of illness or injury	90% of Indemnity Rate (IR); subject to deductible	100% of Network Rate (NR) after a per visit co-payment of $20; not subject to deductible	100% of Network Rate (NR) after a per visit co-payment of $20; not subject to deductible	60% of Out-of-Network Rate (OONR); subject to deductible
Primary Care Physician or Specialist Office or Clinic Visits for the following: • Wellness care/preventive health care • Well-newborn exam • Well-child exams and immunizations • Annual physicals • Annual gynecological exams Notes: Lab and test charges include such services as mammograms, prostate screenings/PSAs, and pap tests. Covered according to preventive care age schedules. Covered care schedules are online at www.healthygeorgia.com or call Member Services at (800) 483-6983 (outside Atlanta) or (404) 233-4479 (inside Atlanta).	90% of IR for office visit after deductible. 100% of IR with no deductible for associated lab and test charges, up to a maximum of $200 per person per Plan year; additional $125 benefit for screening mammogram.	100% of NR after $20 co-payment for office visit. 100% of NR with no co-payment for associated lab and test charges, up to a maximum of $500 per person per Plan year, including office visit charges (less the co-payment); maximum combined with In-Network/Out-of-State benefit.	100% of NR after $20 co-payment for office visit. 100% of NR with no co-payment for associated lab and test charges, up to a maximum of $500 per person per Plan year, including office visit charges (less the co-payment); maximum combined with In-Network/Georgia benefit.	Not covered. Charges do not apply to deductible or annual out-of-pocket limits.

COMPARISON OF PPO AND INDEMNITY OPTIONS

COVERED SERVICES	INDEMNITY OPTION *The Plan Pays:*	PPO OPTION In-Network/Georgia *The Plan Pays:*	PPO OPTION In-Network/Out-of-State *The Plan Pays:*	PPO OPTION Out-of-Network *The Plan Pays:*
Prescription Drugs Purchased at an Express Scripts network pharmacy, regardless of Health Plan option	$10 co-payment for generic drugs; $20 co-payment for preferred brand name drugs; 20% co-insurance for non-preferred brand name drugs, with a $35 minimum and $75 maximum co-payment. Co-payments for generic and preferred brand name drugs are applied to a monthly out-of-pocket maximum of $100 per person and $200 per family. When a member chooses a preferred brand name or non-preferred brand name drug over its generic equivalent, the member may be responsible for a higher co-payment than listed herein. Co-payments are based upon supplies of up to 30 days; some drugs are limited to a standard other than 30-day supplies. See the SPD and *UPDATERs* for details.			
Purchased at an out-of-network pharmacy, regardless of Health Plan Option	Member must pay full charges at point of sale and submit a paper claim. Members will be reimbursed at the pharmacy network rate less the required co-payment for covered drugs. Charges are subject to balance billing. Coverage provisions listed above also apply.			
Maternity Treatment (pre-natal and post-natal)	90% of IR; subject to deductible	90% of NR after an initial visit co-payment of $20; not subject to deductible	80% of NR after an initial visit co-payment of $20; not subject to deductible	60% of OONR; subject to deductible
Laboratory; X-Rays; Diagnostic Tests; Injections, including Medications Covered Under Medical Benefits—for the Treatment of an Illness or Injury	90% of IR; subject to deductible	90% of NR; subject to deductible	80% of NR; subject to deductible	60% of OONR; subject to deductible
Allergy Shots and Serum	90% of IR; subject to deductible	100% of NR; not subject to the deductible. If physician is seen, visit is treated as an office visit subject to the per visit co-payment of $20.	100% of NR; not subject to the deductible. If physician is seen, visit is treated as an office visit subject to the per visit co-payment of $20.	60% of OONR; subject to deductible
Allergy Testing	90% of IR; subject to deductible	90% of NR; subject to deductible	80% of NR; subject to deductible	60% of OONR; subject to deductible

Physician Services Furnished in a Hospital • Surgery in general, including charges by surgeon, anesthesiologist, pathologist, and radiologist	90% of IR; subject to deductible	90% of NR; subject to deductible	80% of NR; subject to deductible	60% of OONR; subject to deductible
• Inpatient well-newborn exams	Not covered	100% of NR; not subject to deductible	100% of NR; not subject to deductible	Not covered
Physician Services That Are for Emergency Care	90% of IR; subject to deductible and to balance billing from non-participating providers	90% of NR; subject to deductible	90% of NR; subject to In-Network/Georgia deductible	90% of NR; subject to In-Network/Georgia deductible and to balance billing
Outpatient Surgery in the physician's office	90% of IR; subject to deductible	90% of NR; subject to deductible	80% of NR; subject to deductible	60% of OONR; subject to deductible
Outpatient Surgery—Hospital/Facility	90% of IR; subject to deductible	90% of NR; subject to deductible	80% of NR; subject to deductible	60% of OONR; subject to deductible
Hospital Services Other Than Those That Are for Emergency Care • Inpatient care, including inpatient short-term acute rehabilitation services	90% of IR; subject to a per admission deductible of $100	90% of NR; subject to deductible	80% of NR; subject to deductible	60% of OONR; subject to deductible
• Outpatient services — Non-emergency use of emergency room — Other	90% of IR; subject to deductible. If services are in conjunction with non-emergency use of emergency room, benefit also subject to $60/visit co-payment.	90% of NR; subject to deductible. If services are in conjunction with non-emergency use of emergency room, benefit also subject to $60/visit co-payment.	80% of NR; subject to deductible. If services are in conjunction with non-emergency use of emergency room, benefit also subject to $60/visit co-payment.	60% of OONR; subject to deductible. If services are in conjunction with non-emergency use of emergency room, benefit also subject to $60/visit co-payment.
• Well-newborn care	90% of IR; subject to a per admission deductible of $100	100% of NR; not subject to deductible	100% of NR; not subject to deductible	Not covered

COMPARISON OF PPO AND INDEMNITY OPTIONS

COVERED SERVICES	INDEMNITY OPTION *The Plan Pays:*	PPO OPTION In-Network/Georgia *The Plan Pays:*	PPO OPTION In-Network/Out-of-State *The Plan Pays:*	PPO OPTION Out-of-Network *The Plan Pays:*
Hospital Services That Are for Emergency Care • Treatment of an emergency medical condition or injury Notes: The $60 co-payment is reduced to $40 if referred by NurseCall 24 before receiving emergency room services.	90% of IR after a per visit co-payment of $60; co-insurance and hospital deductible, if admitted, apply. Subject to balance billing from non-participating providers.	90% of NR after a per visit co-payment of $60; co-insurance and deductible apply	90% of NR after a per visit co-payment of $60; co-insurance and In-Network/ Georgia deductible apply	90% of NR after a per visit co-payment of $60; co-insurance and In-Network/Georgia deductible apply. Subject to balance billing.
Ambulance Services for Emergency Care Notes: Limited to transportation for emergencies and benefits subject to balance billing from non-participating providers of ambulance services.	90% of IR; subject to deductible	90% of NR; subject to deductible	90% of NR; subject to In-Network/Georgia deductible	90% of NR; subject to In-Network/Georgia deductible
Urgent Care Services in an Approved Urgent Care Center	90% of IR; subject to deductible	90% of NR after a per visit co-payment of $35; subject to deductible	90% of NR after a per visit co-payment of $35; subject to deductible	Not applicable
Home Nursing Care Notes: Covers two hours of medically necessary skilled home care per day by RN or LPN if ordered by a physician; limited to $7,500 per Plan year. $7,500 limit is a combined total in PPO Options. Member's share of cost is not applied to Plan year out-of-pocket limits.	90% of IR; subject to deductible	90% of NR; subject to deductible	80% of NR; subject to deductible	60% of OONR; subject to deductible

Hospice Care	100% of IR; subject to deductible and to hospital deductible, if in lieu of hospitalization	100% of NR; subject to deductible	100% of NR; subject to deductible	60% of OONR; subject to deductible
Durable Medical Equipment (DME)—Rental or Purchase	90% of IR; subject to deductible	90% of NR; subject to deductible	80% of NR; subject to deductible	60% of OONR; subject to deductible
Outpatient Acute Short-Term Rehabilitation Services Notes: Coverage for up to 40 visits per Plan year when conditions are met for physical, speech and occupational therapies and for cardiac rehabilitation.	90% of IR; subject to deductible	90% of NR; subject to deductible and $20/visit co-payment	80% of NR; subject to deductible and $20/visit co-payment	60% of OONR; subject to deductible
Dental and Oral Care—Limited Coverage • Coverage in general Notes: Coverage for most procedures for the prompt repair of sound natural teeth or tissue for the correction of damage caused by traumatic injury.	90% of IR; subject to deductible and, if admitted, to hospital deductible	90% of NR; subject to deductible. Network providers may not be available for all covered services; charges are paid at 90% of NR, subject to balance billing.	80% of NR; subject to deductible. Network providers may not be available for all covered services; charges are paid at 80% of NR, subject to balance billing.	60% of OONR; subject to deductible
• Coverage of specific osseous surgeries for the treatment of periodontal disease Notes: Only out-of-network coverage available under Health Plan.	60% of OONR; subject to deductible, not subject to balance billing	60% of OONR; subject to out-of-network deductible, not subject to balance billing	60% of OONR; subject to out-of-network deductible, not subject to balance billing	60% of OONR; subject to out-of-network deductible, not subject to balance billing
• Temporomandibular joint syndrome (TMJ) Notes: Coverage only for diagnostic testing and non-surgical treatment of TMJ, up to $1,100 per person lifetime maximum benefit.	90% of IR; subject to deductible	90% of NR; subject to deductible	80% of NR; subject to deductible	60% of OONR; subject to deductible

COMPARISON OF PPO AND INDEMNITY OPTIONS

COVERED SERVICES	INDEMNITY OPTION *The Plan Pays:*	PPO OPTION In-Network/Georgia *The Plan Pays:*	PPO OPTION In-Network/Out-of-State *The Plan Pays:*	PPO OPTION Out-of-Network *The Plan Pays:*
Chiropractic Care Notes: Coverage for up to a maximum of 40 visits per Plan year.	90% of IR; subject to deductible	90% of NR; subject to deductible and $20/visit co-payment	80% of NR; subject to deductible and $20/visit co-payment	60% of OONR; subject to deductible
Behavioral Health Care With BHS authorization, regardless of Health Plan option	Inpatient hospital services for mental health and substance abuse are covered at 90% of network rate for up to a combined total of 60 days per person, per Plan year; associated professional fees are covered at 80% of network rate for up to 60 visits. Partial/day hospitalization is covered at 90% of network rate for up to 30 days/visits per Plan year. Outpatient professional services for mental health and substance abuse are covered at 80% of network rate for up to 50 visits per Plan year. Visit limitation includes up to three brief situational counseling sessions covered at 100% without deductible. All eligible charges are subject to deductibles ($300 PPO in-network/Georgia; $300 Indemnity Option deductible and $100 per confinement hospital deductible) and to a separate out-of-pocket limit of $2,500 per person, per Plan year. See the SPD and *UPDATERs* for full details on coverage provisions and exclusions.			
Without BHS authorization, regardless of Health Plan option	Inpatient hospital services for mental health and substance abuse are covered at 60% of the average network per diem rate when BHS-precertified for up to a combined total of 60 days per Plan year; associated professional fees are covered at 50% of the network rate for up to 25 visits per Plan year. Outpatient professional (MD/PhD) services for mental health and substance abuse are covered at 50% of the network rate for up to 25 visits per Plan year. All eligible charges are subject to deductibles and do not accumulate toward any out-of-pocket limit. Balance billing may apply. See the SPD and *UPDATERs* for full details on coverage provisions and exclusions.			
Transplant Services	The level of benefit coverage is based on whether or not you select a contracted transplant center, regardless of your Health Plan option. At contracted centers, the level of benefit coverage is 90% of the network rate for covered services. At non-contracted centers, the level of benefit coverage is 60% of the network rate for covered services.			

IMPORTANT CONSIDERATIONS

- Services covered under the PPO from an In-Network/Georgia provider will apply only to the In-Network/Georgia deductible and out-of-pocket limit.
- Services covered under the PPO from in-network/out-of-state and out-of-network providers apply to the same deductible and out-of-pocket limit.
- Lifetime benefit maximums are combined totals among the PPO Options, Indemnity Option, and HMO Options (except for Kaiser Permanente).
- Some PPO annual maximums and limitations are combined totals.
- Annual dollar and visit limitations, deductibles, and out-of-pocket spending limits are based on a July 1 to June 30 Plan year.
- Some services may require MCP precertification, prior approval, or letters of medical necessity before such services are covered by the Plan.
- Co-payments do not apply toward deductibles or out-of-pocket limits unless otherwise noted.
- Co-payments for a prescription drug may change at any time during the Plan year if the class of drug changes. For instance, if a preferred brand is reclassified as a generic, your co-payment would decrease. Also, if a preferred brand is reclassified as a non-preferred brand, your co-payment would increase.
- PPO and Indemnity Options include a discount program for vision screenings and eyewear. Contact the BlueChoice Vision Program at (800) 377-6436 or visit www.bcbsga.com for more information. Vision program availability is subject to change during the Plan year.
- See the SPD and *UPDATERs* for coverage details, including limitations and exclusions.

Comparison of Benefits: HMO Options

The following chart summarizes the benefits offered by the HMOs—BlueChoice, CIGNA, Kaiser Permanente, Kaiser Permanente Medicare+Choice, and UnitedHealthcare. Most covered services are the same for each HMO. If you are trying to choose among HMOs, you should:

- Check the service area covered by each HMO to see if you live in an approved county.
- Check which physicians, specialists, and hospitals are offered through the HMOs' networks. Would you have to switch physicians if you selected a new HMO? Are physicians' offices located near you? Phone numbers and Web sites for the HMOs are listed on the inside front cover.
- Compare covered services and what your premium would be for each.

To help you compare all SHBP options, this HMO chart follows the same format as the PPO and Indemnity Option comparison of benefits. The Kaiser Permanente and Kaiser Permanente Medicare+Choice benefits are the same, except where noted.

HMO COVERED SERVICES

COVERED SERVICES	BLUECHOICE *The Plan Pays:*	CIGNA *The Plan Pays:*	KAISER PERMANENTE and KAISER PERMANENTE MEDICARE+CHOICE (M+C) *The Plan Pays:*	UNITEDHEALTHCARE *The Plan Pays:*
Maximum Lifetime Benefit	$2 million (all SHBP limits combined)	$2 million (all SHBP limits combined)	No lifetime benefit maximums	$2 million (all SHBP limits combined)
Pre-existing Conditions; 1st year in Plan only, subject to HIPAA	None	None	None	None
Lifetime Benefit Limit for Treatment of: • Temporomandibular joint dysfunction (TMJ) • Substance abuse • Organ and tissue transplants • Home hyperalimentation	No separate lifetime benefit limit	No separate lifetime benefit limit	No lifetime benefit maximums	No separate lifetime benefit limit
Deductibles/Co-payments: • Deductible—individual • Deductible—family maximum	Not applicable	Not applicable	Not applicable	Not applicable

continued... • Hospital co-payment/admission • Emergency room co-payment • Urgent care center co-payment	$200 $50 (waived if admitted) $15 with referral	$200 $50 (waived if admitted) $25	$200 $50 (waived if admitted) $30	$200 $50 (waived if admitted) $25
Annual Out-of-Pocket Maximums: • Individual (you or one of your dependents) • Family (you and your dependents)	Not applicable	Not applicable	Not applicable Kaiser Permanente M+C: $1,500 per individual, $4,500 per family, per Plan Year	Not applicable
Primary Care Physician or Specialist Office or Clinic Visits: • Treatment of illness or injury	100% after a per visit co-payment of $15 for primary care and $20 for specialty care	100% after a per visit co-payment of $15 for primary care and $20 for specialty care	100% after a per visit co-payment of $15 for primary care and $20 for specialty care	100% after a per visit co-payment of $15 for primary care and $20 for specialty care
Primary Care Physician or Specialist Office or Clinic Visits for the following: • Wellness care/preventive health care • Well-newborn exam • Well-child exams and immunizations • Annual physicals • Annual gynecological exams	100% after a per visit co-payment of $15 for primary care and $20 for specialty care	100% after a per visit co-payment of $15 for primary care and $20 for specialty care. No co-payment for immunizations and mammograms.	100% after a per visit co-payment of $15 for primary care and $20 for specialty care. No co-payment for immunizations and mammograms.	100% after a per visit co-payment of $15 for primary care and $20 for specialty care No co-payment for immunizations and mammograms.

HMO COVERED SERVICES

COVERED SERVICES	BLUECHOICE *The Plan Pays:*	CIGNA *The Plan Pays:*	KAISER PERMANENTE and KAISER PERMANENTE MEDICARE+CHOICE (M+C) *The Plan Pays:*	UNITEDHEALTHCARE *The Plan Pays:*
Prescription Drugs	100% after your per prescription co-payment	100% after your per prescription co-payment	100% after your per prescription co-payment	100% after your per prescription co-payment
			At Kaiser pharmacy / At Eckerd's	
• Generic	• $10	• $10	• $10 / • $16	• $10
• Preferred brand name	• $20	• $20	• $20 / • $26	• $20
• Non-preferred brand name	• $35	• $35	• Not applicable / • Not applicable	• $35
			Kaiser Permanente M+C:	
• Generic			• $10 / • $16	
• Preferred brand name			• $15 / • $21	
• Non-preferred brand name			• Not applicable / • Not applicable	
Notes: Covers only prescriptions filled at participating local pharmacy or HMO medical center; mail order drug program for maintenance drugs sometimes offered.	Mail order: 90-day supply covered after two co-payments	Mail order: 90-day supply covered after two co-payments	Mail order: Up to 90-day supply; co-payment is per 30-day supply; add $1.50 for shipping fee per prescription	Mail order: 90-day supply covered after two co-payments
Maternity Treatment — Physician Services (pre-natal and post-natal)	100% after an initial co-payment of $20	100% after an initial co-payment of $20	100% after an initial co-payment of $20 Kaiser Permanente M+C: 100% coverage	100% after an initial co-payment of $20
Laboratory; X-Rays; Diagnostic Tests; Injections, including Medications Covered Under Medical Benefits—for the Treatment of an Illness or Injury	100%	100%	100%	100%

Allergy Shots and Serum	100% for shots and serum (if a physician is seen, visit is treated as an office visit subject to the per visit co-payment of $20)	100% for shots and serum (if a physician is seen, visit is treated as an office visit subject to the lesser of the charge or the per visit co-payment of $20)	$5 for shots and $50 for six-month supply of serum Kaiser Permanente M+C: $5 for shots, no charge for serum	100% for shots and serum (if a physician is seen, visit is treated as an office visit subject to the per visit co-payment of $20)
Allergy Testing	100% after per visit co-payment of $20	100% after per visit co-payment of $20	100% after per visit co-payment of $20	100% after per visit co-payment of $20
Physician Services Furnished in a Hospital				
• Surgery in general, including charges by surgeon, anesthesiologist, pathologist, and radiologist	100%	100%	100%	100%
• Inpatient well-newborn exams	100%	100%	100%	100%
Physician Services That Are for Emergency Care	100% after applicable co-payment	100% after applicable co-payment	100% after applicable co-payment	100% after applicable co-payment
Outpatient Surgery in the physician's office	100% after $20 co-payment if billed as office visit; 100% after $100 co-payment if billed as outpatient surgery	100% after $20 co-payment if billed as office visit; 100% after $100 co-payment if billed as outpatient surgery	100% after $20 co-payment if billed as office visit; 100% after $100 co-payment if billed as outpatient surgery	100% after $20 co-payment if billed as office visit; 100% after $100 co-payment if billed as outpatient surgery
Outpatient Surgery—Hospital/Facility	100% after $100 per confinement co-payment	100% after $100 per confinement co-payment	100% after $100 per confinement co-payment	100% after $100 per confinement co-payment
Hospital Services Other Than Those That Are for Emergency Care				
• Inpatient care, including inpatient short-term acute rehabilitation services	100% after $200 per confinement co-payment	100% after $200 per confinement co-payment	100% after $200 per confinement co-payment	100% after $200 per confinement co-payment

HMO COVERED SERVICES

COVERED SERVICES	BLUECHOICE *The Plan Pays:*	CIGNA *The Plan Pays:*	KAISER PERMANENTE and KAISER PERMANENTE MEDICARE+CHOICE (M+C) *The Plan Pays:*	UNITEDHEALTHCARE *The Plan Pays:*
Hospital Services Other Than Those That Are for Emergency Care (continued) • Outpatient services — Non-emergency use of emergency room	Requires prior authorization from PCP, otherwise not covered	Requires prior authorization from PCP, otherwise not covered	Requires prior authorization from PCP, otherwise not covered	Requires prior authorization from HMO, otherwise not covered
• Well-newborn care	100%	100%	100%	100%
Hospital Services That Are for Emergency Care • Treatment of an emergency medical condition or injury	100% after a per visit co-payment of $50 (co-payment waived if admitted)	100% after a per visit co-payment of $50 (co-payment waived if admitted)	100% after a per visit co-payment of $50 (co-payment waived if admitted)	100% after a per visit co-payment of $50 (co-payment waived if admitted)
Ambulance Services for Emergency Care	100%	100%	100% after a $50 co-payment per trip when medically necessary	100%
Urgent Care Services in an Approved Urgent Care Center	100% after a $15 co-payment, referral required	100% after a $25 co-payment	100% after a $30 co-payment	100% after a $25 co-payment
Home Nursing Care	100%; up to 120 days per Plan year	100%; up to 120 days per Plan year	100%; up to 120 days per Plan year Kaiser Permanente M+C: 100%; no day limit	100%; up to 120 days per Plan year
Hospice Care	100%; prior approval is required	100%; prior approval is required	100%; prior approval is required	100%; prior approval is required

Durable Medical Equipment (DME)—Rental or Purchase	100% when medically necessary	100% when medically necessary	100% when medically necessary	100% when medically necessary
Outpatient Acute Short-term Rehabilitation Services	100% after a $20 co-payment per visit; up to 40 visits per Plan year	100% after a $20 co-payment per visit; up to 40 visits per Plan year	100% after a $20 co-payment per visit; up to 40 visits per Plan year or up to two consecutive months per condition, whichever is more Kaiser Permanente M+C: Physical, occupational and speech therapy: 100% coverage after $20 co-payment; unlimited vistis per Plan year	100% after a $20 co-payment per visit; up to 40 visits per Plan year
Dental and Oral Care—Limited Coverage • Coverage in general	100% after applicable co-payment for oral surgery and dental services associated with an accidental injury to sound teeth	100% after applicable co-payment for oral surgery and dental services associated with an accidental injury to sound teeth	Services and appliances for accidental injury to sound and natural teeth: 50% coverage for first $1,000, then 100% thereafter	100% after applicable co-payment for oral surgery and dental services associated with an accidental injury to sound teeth
• Coverage of specific osseous surgeries for the treatment of periodontal disease	Not covered	Not covered	Not covered	Not covered
• Temporomandibular joint syndrome (TMJ)	100% after applicable co-payment, subject to limitations	100% after applicable co-payment, subject to limitations	50% for non-surgical treatment	100% after applicable co-payment, subject to limitations
Chiropractic Care	100% after $20 co-payment per visit; limited to 20 visits per Plan year	100% after $20 co-payment per visit; limited to 20 visits per Plan year	100% after $20 co-payment per visit; limited to 20 visits per Plan year	100% after $20 co-payment per visit; limited to 20 visits per Plan year

HMO COVERED SERVICES

COVERED SERVICES	BLUECHOICE *The Plan Pays:*	CIGNA *The Plan Pays:*	KAISER PERMANENTE and KAISER PERMANENTE MEDICARE+CHOICE (M+C) *The Plan Pays:*	UNITEDHEALTHCARE *The Plan Pays:*
Behavioral Health Care (Mental health and substance abuse care)	For inpatient care: 100% after $50 co-payment per confinement; limited to 30 days per Plan year. For outpatient care: 100% after $20 co-payment per visit; limited to 25 visits per Plan year.	For inpatient care: 100% after $50 co-payment per confinement; limited to 30 days per Plan year. For outpatient care: 100% after $20 co-payment per visit; limited to 25 visits per Plan year.	Mental health: Inpatient services are covered at 100% after a $50 co-payment per admission; unlimited days. Outpatient services covered at 100% after $20 co-payment per visit; unlimited visits. Substance abuse: Inpatient services covered at 100% after a $50 co-payment per admission; up to 30 days per Plan year. Outpatient services covered at 100% after $20 co-payment per visit; up to 25 visits per Plan year. Detoxification: Co-payments same as above. No coverage limits on number of episodes, inpatient days or outpatient visits.	For inpatient care: 100% after $50 co-payment per confinement; limited to 30 days per Plan year. For outpatient care: 100% after $20 co-payment per visit; limited to 25 visits per Plan year.
Transplant Services	100%	100%	100%	100%

IMPORTANT CONSIDERATIONS

- Annual dollar and visit limitations are based on a July 1 to June 30 Plan year.
- Some services may require prior authorization by the HMO before such services are covered. Also, some services may have limitations not contained in this summary.
- Most HMOs require the selection of a primary care physician (PCP) to manage your care. Failure to specify a PCP could delay receipt of your ID card. However, in some instances, the HMO assigns you a PCP located near your residence if a PCP is not specified. Note: UnitedHealthcare does not require the selection of a PCP.
- Most HMOs require you to obtain referrals to see most specialists. Failure to obtain a referral could result in a denial of your claim. Note: UnitedHealthcare does not require referrals for coverage of specialist services.
- Each HMO Option may offer vision care discounts or benefits. Contact the HMO directly for more information.
- Contact the HMO directly for more details regarding covered services, exclusions, and limitations.

Service Areas for Your Health Plan Options

Service Areas

Service areas are State-approved geographic areas, such as counties or zip codes, where providers participate in the network offered by the Plan option in which you have enrolled.

PPO and PPO Choice Option

Georgia Service Area

The Georgia service area includes the state of Georgia and the border communities of the Chattanooga, Tennessee area, including Bradley County; and Phenix City, Alabama. The zip code area in which you **receive a service** is used to determine whether or not you are in the Georgia service area. If you receive covered services from an MRN/Georgia 1st provider located in one of the zip codes below, you receive the highest level of coverage available in the PPO options.

Georgia:

All counties; all zip codes

Alabama:

Russell County (Phenix City area): 36851, 36856, 36858, 36859, 36860, 36867, 36868, 36869, 36870, 36871, and 36875.

Tennessee:

Bradley County (Cleveland area): 37310, 37311, 37312, 37320, 37323, 37353 and 37364.

Hamilton County (Chattanooga area): 37302, 37304, 37308, 37315, 37341, 37343, 37350, 37351, 37363, 37373, 37377, 37379, 37384, 37401, 37402, 37403, 37404, 37405, 37406, 37407, 37408, 37409, 37410, 37411, 37412, 37414, 37415, 37416, 37419, 37421, 37422, 37424, and 37450.

Out-of-State/National Service Area

The out-of-state service area includes all national locations outside of the Georgia service area described to the left. By using Beech Street providers outside of the Georgia service area, you are protected against being charged more than what the Plan allows. However, use of Beech Street providers inside the Georgia service area is considered out-of-network care with lower levels of benefit coverage and a separate deductible and out-of-pocket maximum, unless the provider also participates in the MRN/Georgia 1st network.

HMO Options

You must live in the HMO's approved service area to be eligible for coverage under that option. Below are the regular HMO Option service areas by county. If you live or work in a county marked "Yes" under any of the HMOs listed, you may enroll in that HMO. If the county where you live is not listed below, you are not eligible for regular HMO coverage.

County of Residence	BlueChoice	CIGNA	Kaiser Permanente	UnitedHealthcare
Appling	Not Available	Yes	Not Available	Not Available
Bacon	Not Available	Yes	Not Available	Yes
Baldwin	Not Available	Yes	Not Available	Not Available
Banks	Yes	Not Available	Not Available	Yes
Barrow	Yes	Yes	Yes	Yes
Bartow	Yes	Yes	Yes	Yes
Ben Hill	Not Available	Not Available	Not Available	Yes
Berrien	Not Available	Not Available	Not Available	Yes
Bibb	Yes	Yes	Not Available	Yes
Bleckley	Yes	Yes	Not Available	Yes
Brooks	Not Available	Yes	Not Available	Yes
Bryan	Yes	Yes	Not Available	Yes
Bulloch	Yes	Yes	Not Available	Yes
Burke	Yes	Yes	Not Available	Yes
Butts	Yes	Yes	Yes	Yes
Candler	Not Available	Yes	Not Available	Yes
Carroll	Yes	Not Available	Not Available	Not Available
Catoosa	Not Available	Yes	Not Available	Not Available
Chatham	Yes	Yes	Not Available	Yes
Chattahoochee	Yes	Not Available	Not Available	Not Available
Chattooga	Yes	Yes	Not Available	Yes
Cherokee	Yes	Yes	Yes	Yes
Clarke	Yes	Yes	Not Available	Not Available
Clayton	Yes	Yes	Yes	Yes
Cobb	Yes	Yes	Yes	Yes
Colquitt	Not Available	Yes	Not Available	Yes
Columbia	Yes	Yes	Not Available	Yes
Coweta	Yes	Yes	Yes	Yes
Crawford	Yes	Not Available	Not Available	Yes
Dade	Not Available	Yes	Not Available	Not Available
Dawson	Yes	Not Available	Not Available	Yes
Decatur	Not Available	Yes	Not Available	Not Available

County of Residence	BlueChoice	CIGNA	Kaiser Permanente	UnitedHealthcare
DeKalb	Yes	Yes	Yes	Yes
Dodge	Not Available	Yes	Not Available	Not Available
Douglas	Yes	Yes	Yes	Yes
Early	Not Available	Yes	Not Available	Yes
Effingham	Yes	Yes	Not Available	Yes
Elbert	Yes	Yes	Not Available	Not Available
Emanuel	Yes	Yes	Not Available	Yes
Evans	Not Available	Yes	Not Available	Yes
Fannin	Not Available	Yes	Not Available	Not Available
Fayette	Yes	Yes	Yes	Yes
Floyd	Yes	Yes	Not Available	Yes
Forsyth	Yes	Yes	Yes	Yes
Franklin	Yes	Yes	Not Available	Not Available
Fulton	Yes	Yes	Yes	Yes
Gilmer	Yes	Not Available	Not Available	Not Available
Glascock	Yes	Not Available	Not Available	Yes
Gordon	Yes	Yes	Not Available	Yes
Grady	Not Available	Yes	Not Available	Yes
Greene	Yes	Yes	Not Available	Yes
Gwinnett	Yes	Yes	Yes	Yes
Habersham	Not Available	Not Available	Not Available	Yes
Hall	Yes	Yes	Yes	Yes
Harris	Yes	Yes	Not Available	Not Available
Hart	Yes	Not Available	Not Available	Not Available
Heard	Yes	Not Available	Not Available	Not Available
Henry	Yes	Yes	Yes	Yes
Houston	Yes	Yes	Not Available	Yes
Jackson	Yes	Yes	Not Available	Yes
Jasper	Not Available	Not Available	Not Available	Yes
Jefferson	Yes	Yes	Not Available	Yes
Jenkins	Yes	Not Available	Not Available	Yes
Johnson	Yes	Not Available	Not Available	Not Available
Jones	Yes	Yes	Not Available	Yes
Lamar	Not Available	Not Available	Not Available	Yes
Lanier	Not Available	Not Available	Not Available	Yes
Laurens	Not Available	Yes	Not Available	Not Available
Liberty	Yes	Yes	Not Available	Yes

County of Residence	BlueChoice	CIGNA	Kaiser Permanente	UnitedHealthcare
Lincoln	Yes	Yes	Not Available	Yes
Long	Not Available	Yes	Not Available	Yes
Lowndes	Not Available	Yes	Not Available	Yes
Lumpkin	Yes	Not Available	Not Available	Yes
Madison	Yes	Yes	Not Available	Not Available
Marion	Yes	Yes	Not Available	Not Available
McDuffie	Yes	Yes	Not Available	Yes
Meriwether	Yes	Not Available	Not Available	Yes
Mitchell	Not Available	Yes	Not Available	Yes
Monroe	Yes	Not Available	Not Available	Yes
Morgan	Yes	Not Available	Not Available	Yes
Muscogee	Yes	Yes	Not Available	Not Available
Newton	Yes	Yes	Yes	Yes
Oconee	Yes	Yes	Not Available	Not Available
Oglethorpe	Yes	Yes	Not Available	Not Available
Paulding	Yes	Yes	Yes	Yes
Peach	Yes	Yes	Not Available	Yes
Pickens	Yes	Not Available	Not Available	Yes
Pike	Not Available	Not Available	Not Available	Yes
Polk	Yes	Yes	Not Available	Yes
Pulaski	Yes	Yes	Not Available	Yes
Putnam	Not Available	Not Available	Not Available	Yes
Richmond	Yes	Yes	Not Available	Yes
Rockdale	Yes	Yes	Yes	Yes
Screven	Not Available	Yes	Not Available	Yes
Seminole	Not Available	Yes	Not Available	Yes
Spalding	Yes	Yes	Yes	Yes
Stewart	Yes	Not Available	Not Available	Not Available
Sumter	Not Available	Yes	Not Available	Not Available
Talbot	Yes	Not Available	Not Available	Not Available
Taliaferro	Not Available	Not Available	Not Available	Yes
Tattnall	Not Available	Yes	Not Available	Yes
Taylor	Not Available	Yes	Not Available	Not Available
Thomas	Not Available	Yes	Not Available	Yes
Tift	Not Available	Not Available	Not Available	Yes
Toombs	Not Available	Yes	Not Available	Yes
Twiggs	Yes	Not Available	Not Available	Yes

County of Residence	BlueChoice	CIGNA	Kaiser Permanente	UnitedHealthcare
Upson	Not Available	Yes	Not Available	Not Available
Walker	Not Available	Yes	Not Available	Not Available
Walton	Yes	Yes	Yes	Yes
Ware	Not Available	Not Available	Not Available	Yes
Warren	Yes	Not Available	Not Available	Yes
Washington	Yes	Not Available	Not Available	Not Available
Wayne	Not Available	Not Available	Not Available	Yes
White	Yes	Not Available	Not Available	Yes
Whitfield	Not Available	Yes	Not Available	Not Available
Wilkes	Yes	Yes	Not Available	Yes
Wilkinson	Yes	Yes	Not Available	Not Available
Worth	Not Available	Not Available	Not Available	Yes

Medicare+Choice HMO Option

County of Residence	Kaiser Permanente M+C HMO
Cherokee	Yes
Clayton	Yes
Cobb	Yes
Coweta	Yes
DeKalb	Yes
Douglas	Yes
Fayette	Yes
Forsyth	Yes
Fulton	Yes
Gwinnett	Yes
Henry	Yes
Paulding	Yes, only if you live in zip code 30127, 30134, or 30141

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 SHBP coverage.

The PPO 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 pre-existing condition 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 dependents can reduce the 12-month pre-existing condition limitation period. The reduction is possible by using what is called "creditable coverage" to offset a pre-existing condition period. Creditable coverage generally includes the health coverage 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 pre-existing condition 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.

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

Within two years after your dependent's former coverage terminated, he/she has the right to obtain a letter of creditable coverage from his/her former employer(s) to offset the pre-existing condition limitation period under the SHBP. The SHBP will evaluate the certificate of 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. You have the right to appeal any decision related to a prior creditable coverage determination.

Please submit the letter of creditable coverage to the Plan with your dependent's enrollment paperwork.

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:

- 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; and
- Treatment of physical complications at any stage of the mastectomy, including lymphedemas.

Note: Reconstructive surgery requires prior approval and all inpatient admissions require MCP precertification.

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.

Penalties for Misrepresentation

If any SHBP participant misrepresents the facts when applying for dependent coverage, change of coverage, or benefits, the SHBP may terminate the person's participation (and that of his or her dependents) and seek legal recovery of any money paid out by the SHBP as a result of the misrepresentation.

Disclaimer

This material is for informational purposes only and is neither an offer of coverage nor medical advice. It contains only a partial, general description of Plan or program benefits and does not constitute a contract or any part of one. For a complete description of the benefits available to you, including procedures, exclusions, and limitations, refer to your specific Plan documents, which may include the State Health Benefit Plan Summary Plan Description, Summary of Material Modification (UPDATER), Schedule of Benefits, Certificate of Coverage, Group Agreement, Group Insurance Certificate, Group Insurance Policy, and any applicable riders to your Plan. All the terms and conditions of your Plan or program are subject to and governed by applicable contracts, laws, regulations, and policies. Certain services, including but not limited to non-emergency inpatient hospital care, require precertification. All benefits are subject to coordination of benefits unless noted otherwise. In case of a conflict between your Plan documents and this information, the Plan documents will govern.

Medicare is a program of the federal government. The information in this Guide is intended only to be a helpful summary of Medicare and not a complete explanation of the program. For more detailed information, contact your local Medicare office. In the event of a conflict between this summary and the Medicare program, Medicare's provisions govern.

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