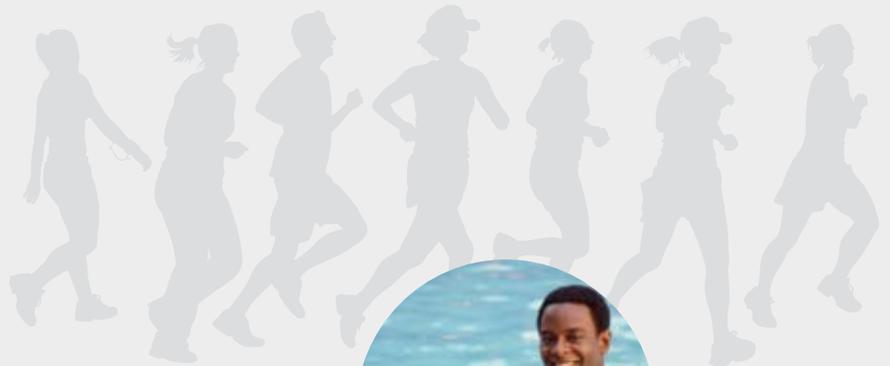




GEORGIA DEPARTMENT OF
COMMUNITY HEALTH



ACTIVE EMPLOYEE



State Health Benefit Plan Decision Guide 2008



OPEN ENROLLMENT October 10 – November 9, 2007

Phone Numbers/Contact Information

State Health Benefit Plan (SHBP): www.dch.georgia.gov/shbp_plans

Vendor	Member Services	Pharmacy	Web Site
UnitedHealthcare			
Definity HRA	800-396-6515		www.myuhc.com/groups/gdch
PPO and Indemnity	877-246-4189 TDD 800-955-8770	877-650-9342	www.myuhc.com/groups/gdch
Choice HMO	866-527-9599 TDD 800-955-8770		www.myuhc.com/groups/gdch
HDHP	877-246-4195 TDD 800-842-5754	877-246-4195	www.myuhc.com/groups/gdch
Blue Cross Blue Shield of GA			
Lumenos HRA	866-835-6863		www.info.lumenos.com
HMO	800-464-1367		www.bcbsga.com
Kaiser Permanente	800-611-1811 TDD 800-255-0056		www.kaiserpermanente.org
Pharmacy		Contact your respective vendor	www.dch.georgia.gov/shbp_plans
All Options: Eligibility	404 656-6322 800 610-1863		www.dch.georgia.gov/shbp_plans
Plan Cost Estimator			www.dch.georgia.gov/shbp_plans

Disclaimer: This material is for informational purposes and is not a contract. It is intended only to highlight principal benefits of the medical plans. Every effort has been made to be as accurate as possible; however, should there be a difference between this information and the Plan documents, the Plan documents govern. It is the responsibility of each member, active or retired, to read all Plan materials provided in order to fully understand the provisions of the option chosen. Availability of SHBP options may change based on changes in federal or state law.

Page 2 of this guide contains Plan changes effective January 1, 2008. Prior to the start of the 2008 Plan Year, or shortly thereafter, the Plan will post a new Summary Plan Description (SPD) for each Plan option to the DCH Web site, www.dch.georgia.gov/shbp_plans. This SPD is your official notification of Plan changes effective January 1, 2008. You may print or request a paper copy by calling the Customer Service number on the back of your ID card. Please keep your Summary Plan Description (SPD) for future reference. If you are disabled and need this information in an alternative format, call the 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.



GEORGIA DEPARTMENT OF
COMMUNITY HEALTH

Rhonda M. Medows, MD, Commissioner

Sonny Perdue, Governor

2 Peachtree Street, NW
Atlanta, GA 30303-3159
www.dch.georgia.gov

October 1, 2007

Dear SHBP Member:

Welcome to 2008 Open Enrollment. Open Enrollment dates will be October 10 – November 9, 2007. Employees will again make their health election on the Web at www.oe2008.ga.gov.

The State Health Benefit Plan (SHBP) strives to bring the best value to its members. We have heard your feedback and ideas for improvement and are happy to announce two exciting new options that will be offered January 1, 2008.

These options are based on the idea that you should have greater control over how you spend your health care dollars using tools that help you make informed decisions. These new options address two of the largest challenges in our health care system: improving access to affordable, high-quality care and controlling costs.

These consumer driven health plan options with a Health Reimbursement Account (HRA) will be offered by UnitedHealthcare Definity and BlueCross BlueShield of Georgia Lumenos. Each year SHBP will contribute dollars to your HRA for treatment of medical expenses. In 2008, this amount is \$500 for single coverage and \$1,000 for family coverage. If you use up the credits in your HRA account, there is a deductible to meet, and then the plan works very similar to the PPO with co-insurance and in-network and out-of-network benefits. If you have money in your account left over at the end of the year, this is then rolled over to the next year and combined with SHBP's new deposit.

Each plan also provides 100 percent unlimited coverage for wellness care subject to age and gender guidelines. Your wellness expenses are not charged to your HRA.

The Georgia Department of Community Health, which administers the SHBP, is committed to providing you with meaningful choices in your options and keeping costs down. Be assured that we will continue to seek to provide you with the meaningful options, low premiums and tools to help you make the best decisions for you and your family members.

Sincerely,

Rhonda M. Medows, M.D.

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Welcome to Open Enrollment for the State Health Benefit Plan for Coverage Effective January 1, 2008 – December 31, 2008

The Open Enrollment dates are Wednesday, October 10 through Friday, November 9, 2007. This guide will provide you with a brief explanation of each Plan option, important changes in your SHBP options, steps on how to make your Open Enrollment election, information about the health and wellness features available through the health plan options and a comparison of benefits chart. This guide, the *Active Employee Decision Guide*, can also be found at www.dch.georgia.gov/shbp_plans or www.oe2008.ga.gov.

Employees will make their health election at www.oe2008.ga.gov and the Web site will be open beginning 12:01 a.m. on October 10 and will close at 4 p.m. on November 9, 2007.

What's Changing for 2008?

New Offerings

The SHBP will be offering two new consumer driven health plan options statewide through UnitedHealthcare Definity HRA and BlueCross BlueShield of Georgia Lumenos HRA. Advantages of these options are:

- A Health Reimbursement Account (HRA) funded by SHBP that provides first dollar coverage for Single Coverage (\$500) and Family Coverage (\$1,000)
- 100 percent unlimited wellness benefit based on national age and gender guidelines.
See page 8 for more details

SHBP Acronyms

BCBSGa – BlueCross BlueShield of Georgia

CCO – Consumer Choice Option

DCH – Georgia Department of Community Health

FSA – Flexible Spending Account

HDHP – High Deductible Health Plan

HMO – Health Maintenance Organization

HRA – Health Reimbursement Account

HSA – Health Savings Account

PPO – Preferred Provider Organization

SHBP – State Health Benefit Plan

SPD – Summary Plan Description

UHC – UnitedHealthcare

Wellness Enhancement Expansion

In 2008, SHBP is enhancing its focus on wellness and consumerism. Each employee and family member is encouraged to take a personal health assessment under the plan option of your choice to evaluate your health risk for certain medical conditions. The SHBP wants you to become a more knowledgeable consumer about your health and well-being. Medical statistics show better outcomes for early detection of identified health issues that are treated before they become more serious. In addition, support tools are available to help you make informed decisions about how you spend your health care dollars.

- The PPO wellness benefit is increasing from \$500 to \$1,000 per covered individual based on national age and gender guidelines
- The HDHP wellness benefit is increasing from \$500 to 100 percent unlimited coverage per covered individual based on national age and gender guidelines

No Longer Offered

- The Indemnity Option will be offered **only** to individuals currently enrolled in this option
- The CIGNA Option will **no longer be offered**. If you do not elect a new option and answer the surcharge questions, you and your dependents' coverage will be automatically enrolled in the PPO Option and applicable surcharges will apply for the 2008 Plan Year
- The TRICARE Supplement will **no longer be offered**. If you do not elect a new option and answer the surcharge questions, you and your dependents' coverage will be automatically enrolled in the PPO Option and applicable surcharges will apply for the 2008 Plan Year

Network Changes

- BlueChoice HMO will be adding Appling, Dade, Dodge, Gordon, Hancock, Stephens, Walker and Webster counties to their service area
- Kaiser Permanente will be adding Carroll, Dawson, Haralson, Heard, Lamar, Meriwether, Pickens and Pike counties to their service area

Premiums

For the last 18 months, SHBP members have enjoyed the benefit of a stable premium. However, for the new 2008 Plan Year, premiums will increase by 10 percent. Most large employers have increases of 10 percent or more each year. The SHBP is self-funded, which means that our costs increase as a direct result of our increased claims expenses. While health care costs continue to rise, the SHBP still pays approximately 75 percent of the total cost of your health care benefits.

Eligibility Changes

Services will not be covered for any dependents that have not been verified by SHBP. If you have not yet verified a dependent you wish to cover, SHBP will request documentation verifying the eligibility of your dependent. **Failure to submit the documents within 31 days from SHBP's request will result in the dependent being ineligible for coverage until the following Open Enrollment, or unless a qualifying event occurs.** See page 12 for the definition and more information about qualifying events.

Open Enrollment

Who Must Participate in Open Enrollment?

EVERYONE who wants to:

- Continue health coverage and not pay surcharges
- Add or disenroll eligible dependents
- Change health coverage options
- Discontinue coverage
- Enroll for health coverage

Additionally, **CIGNA, CIGNA CCO and TRICARE Supplement members** must make an election for a new option.

SHBP Plan Options

BlueCross BlueShield of Georgia

- *New* – Lumenos with HRA
- BlueChoice HMO

UnitedHealthcare

- *New* – Definity with HRA
- High Deductible Health Plan (HDHP)*
- Preferred Provider Organization (PPO)
- UnitedHealthcare Choice HMO
- Indemnity (if currently enrolled only)

**This option allows you to set up a Health Savings Account. See page 9 for more information.*

Kaiser Permanente

- HMO

Each Plan offers a Consumer Choice Option (CCO), which allows you to nominate a provider who is not participating in the network so that benefits may be paid at the in-network rate. *See page 11 for more information.*

What Should I Do Before I Go Online for Open Enrollment?

- Evaluate your health care needs
- Read this *Decision Guide* completely for important information about Plan changes
- Check to see if your option will be offered in 2008
- Use the Plan Cost Estimator available at www.dch.georgia.gov/shbp_plans
- Check premium rates with your employer or at www.dch.georgia.gov/shbp_plans to help you decide between options
- Call each Plan option or go to the vendor Web site to see which option your physician or provider participates in
- Check Preferred Drug List
- Check browser requirements – you will need Internet Explorer 5.5 or higher

Go online at www.oe2008.ga.gov October 10 – November 9, 2007 to complete Open Enrollment. It's fast, easy, and secure! If you do not have access, please go to your human resources department for assistance.

Follow These Steps to Make Your Online Open Enrollment Election

- 1) Go to www.oe2008.ga.gov
 - a) Register the first time you logon, by clicking on “Register”
 - b) Enter your policy number and date of birth
 - c) Select, enter and re-enter the password to confirm
 - d) Select a security question and answer it
 - e) Complete by clicking “Register”
2. Now you are on the “login” screen. Re-enter your policy number, password and then click on “Login”
3. After reading the “Terms of Use” text, scroll to the end of the text, click on the “Agree” box, and click “Accept”
4. Your name, address and current coverage tier will display. If needed, make any changes
5. If single-tier is chosen, you will proceed to the surcharge questions. If you choose family-tier, the dependents screen will appear. Indicate ‘Yes’ or ‘No’ for each dependent to be covered. If you wish to add a new dependent, click on “Add Dependent”, input the new dependent information, and click the “Add Dependent” button. Your new dependent should appear
6. Answer the surcharge questions
7. Select your health benefit coverage option
8. Review your health benefit election, listed dependents and check your answers to the surcharge questions on the Pre-confirmation page. If your election is not correct, make any corrections through the edit function. Click ‘Confirm’ to finalize your election
9. Click ‘Printer Friendly’ to produce an easy to print version of your confirmation page, which will include a confirmation number. This reflects your 2008 benefit election. You may also save your confirmation on your computer or to a disk by saving the printer friendly confirmation as a pdf file. Each time you login to the system and confirm your choices, you will receive a unique confirmation number, which you should print or save. The benefits elected and confirmed as of 4 p.m. on November 9, 2007 will be your benefit election for the 2008 Plan Year. *NOTE: If a confirmation number does not show, you have not completed the process. You must click “Confirm” to complete your election. If you are unable to print or save this page, copy the confirmation number and keep it in a safe place*
10. **Do not wait until the last minute** to go online to make your election for 2008 as Web traffic may be heavy and exceptions will not be allowed if you were unable to complete your 2008 election. *REMINDER: the Web site will close at 4 p.m. EST on November 9, 2007*

If you are unable to access www.oe2008.ga.gov to make your OE election, contact your personnel/payroll office prior to the close of OE.



health tip:

Eat a diet rich in vegetables, fruits, whole grains and fiber. Limit your salt intake.

SHBP Surcharges

You should read and understand SHBP's surcharge policy prior to making your health election for 2008.

Spousal

A \$30 per month spousal surcharge will be added to your monthly premium if you elect to cover your spouse and your spouse is eligible for coverage through his/her employment, but chooses not to elect that coverage. If your spouse is eligible for coverage with SHBP through his/her employment, the spousal surcharge will be waived. You will automatically be charged the surcharge if you fail to go online and answer all questions concerning the surcharge. The surcharge will apply to your premium for the 2008 Plan Year.

Tobacco

A \$40 per month tobacco surcharge will be added to your monthly premium for the Plan Year 2008 if you or any of your covered dependents have used tobacco products in the previous 12 months or if you fail to go online and answer these questions. The surcharge will apply to your premium for the 2008 Plan Year.

The tobacco surcharge may be removed by completing the tobacco cessation requirements. Details are available at www.dch.georgia.gov/shbp_plans.

What Happens if I Don't Go Online During Open Enrollment?

You will retain the same coverage option and tier (single or family) you currently have but **surcharges will apply**. If you are enrolled in CIGNA, CIGNA CCO, or the TRICARE Supplement and fail to go online to make a new health election, you will automatically be enrolled in the PPO Option effective January 1, 2008, and you **will be assessed the tobacco surcharge and the spousal surcharge (if your spouse is covered)**. You will pay these surcharges for all of the 2008 Plan Year unless you experience a qualifying event.

State Personnel Administration (SPA) Flexible Benefits

Program Participants [formerly Georgia Merit System (i.e. dental, life, etc.)]

- You will need to go to www.oe2008.ga.gov to make your health benefit election. You should print your confirmation page and make sure it contains a confirmation number. This number confirms your health benefit election for 2008
- If you are eligible for SPA flexible benefits (i.e. dental, life, etc.), you will need to go to a separate Web site, www.gabenefits.org. You should confirm your flexible benefits elections and print your confirmation statement that includes the confirmation number for your elections

Your 2008 elections must be made on two separate Web sites and you must confirm on both. You should print your confirmations (health and flex) and make sure they both contain confirmation numbers.

Board of Education or Agencies Not Participating in the SPA Flexible Benefits Program (formerly the Georgia Merit System)

You will need to make your health election on www.oe2008.ga.gov, print your confirmation and make sure it contains a confirmation number. This number confirms your health benefit election for 2008. Contact your personnel/payroll office to obtain information regarding your flexible benefits.

Health & Wellness

The health plans offer education on healthy living initiatives. The goal is to provide enhanced information, tools, and support to promote your healthy lifestyle and meet your health care needs. Please refer to your health Plan option for details on programs offered.

- **Personal Health Assessments** – each vendor has a personal health assessment questionnaire available on their Web site that you can complete. This information is kept confidential and will indicate potential health risks. The vendor may contact you regarding steps you can take to control or eliminate this risk or tests you may want to consider
- **Health Management Services** – each vendor offers assistance with health care services such as disease management, case management and behavioral health. Please refer to your health plan option for additional details on programs offered
- **Nurse Advice Line** – each vendor has a 24-hour, seven days a week (including holidays) nurse advice line that is available to assist you in making informed decisions about your health. You can call for professional medical advice regarding medical situations. Check with your health plan option for the telephone number



health tip:

Experts agree that exercise is the best predictor of long-term weight control. Rapid weight loss can lower your metabolism because the body thinks it is starving and makes it harder to lose weight.

Understanding Your Plan Options

To maximize your health benefits, it is important to fully understand how each SHBP option works. This brief overview will help you determine which option best fits your health care needs. **Keep in mind that failure to use in-network providers could cost you more.**

Consumer Driven Health Plan Options

HRA and HSA participation impacts your eligibility and the amount you can contribute to a Flexible Spending Account. Additional information to assist you with understanding the rules and differences can be found on page 22 of this *Decision Guide*.

Health Reimbursement Account (HRA)

The HRA is a consumer driven health care option whose plan design offers you a different approach for managing your health care needs. It is similar to that of the PPO with an in-network and out-of-network benefit, except the SHBP funds \$500 for single coverage and \$1,000 for family coverage to a HRA that can be used to provide first dollar coverage for eligible health care expenses including pharmacy. The amount in your HRA helps offset the deductible (bridge). The Plan also offers unlimited wellness benefits based on age and gender national guidelines when seeing in-network providers only. You will pay co-insurance after you have satisfied the deductible rather than co-payments for medical expenses and prescription drugs.

The BlueCross BlueShield of Georgia Lumenos with Health Reimbursement Account (HRA) offers a network of more than 700,000 participating physicians through the BlueCross BlueShield BlueCard PPO Network. **The BCBSGa Lumenos HRA Plan requires that after using all HRA dollar credits, you satisfy the entire family deductible before any benefits are paid.** This does not apply to wellness. You do not have to pay the provider at the time of service except for pharmacy. *See pages 14–21 for a benefits comparison.*

The UnitedHealthcare (UHC) Definity with Health Reimbursement Account (HRA) offers a network of more than 520,000 participating physicians through the UHC PPO Network. The UHC Definity HRA Plan offers a debit card that can be used when seeing in-network providers or when purchasing prescription drugs from an in-network pharmacy. *See pages 14–21 for a benefits comparison.*

Considerations:

- Unused dollars in your HRA account rollover to the next Plan Year if you are still participating in this option
- HRA dollar credits can be used with the HRA Option only
- If you enroll during the year, your HRA dollar credits will be pro-rated based on the number of months remaining in the Plan Year (which is calendar)
- If you experience a qualifying event and change tiers from single to family coverage, your new HRA dollar credits will be pro-rated based on the number of months remaining in the Plan Year
- If you experience a qualifying event and change tiers from family to single coverage, your HRA dollar credits will not be reduced
- Unused dollars in the HRA account will be forfeited if you change options during the Open Enrollment or qualifying event or terminate employment, even if you re-enroll in a subsequent Plan Year
- There is not a separate deductible and co-insurance for out-of-network



health tip:

No more than 30 percent of your daily calories should be from fat.

High Deductible Health Plan (HDHP) with a Health Savings Account (HSA)

The High Deductible Health Plan (HDHP) is a consumer driven health care option whose plan design is very similar to that of the PPO with an in-network and out-of-network benefit. The HDHP offers you the use of the UHC PPO network. This option offers 100 percent unlimited wellness benefits based on national age and gender guidelines. In return for a low monthly premium, you must satisfy a higher deductible that applies to all health care expenses except preventive care. **If you have family coverage, you must meet the family deductible before benefits are payable for any family member.** You pay co-insurance after you have satisfied the deductible rather than set dollar co-payments for medical expenses and prescription drugs. Also, you may qualify to start a Health Savings Account (HSA) for yourself and set aside tax-free dollars to pay for eligible health care expenses now or in the future. HSAs typically earn interest and may even offer investment options. *See the benefits comparison chart that starts on page 14 to compare benefits under the HDHP to other Plan options.*

HDHP Considerations:

- You must satisfy a separate in-network and out-of-network deductible
- You must satisfy the family deductible before benefits are payable for any member
- You pay co-insurance after meeting the family deductible for all medical expenses

Health Savings Account (HSA)

An HSA is like a personal savings account with investment options for health care, except it's all tax-free. You may be eligible to participate in an HSA that is offered through the State of Georgia Flexible Benefits Program or by your employer. Participation through payroll deductions allows your contributions to be pre-tax. If your employer opted not to offer an HSA, you may still open an HSA with an independent HSA administrator/custodian. You may locate HSA Administrators at www.hsafinder.com/sitemap.shtml.

You may open an HSA if you enroll in the SHBP HDHP and do not have other coverage through: 1) Your spouse's employer's plan 2) Medicare 3) Medicaid 4) Health Care Spending Account (HCSA) or any other non-qualified medical plan.

- You can make contributions to an HSA only when enrolled in the HDHP as an active member (employee or retiree)
- You can contribute up to \$2800 single, \$5800 family as long as you are enrolled in the HDHP. Limits are set by federal law. Unused money in your account carries forward to the next Plan Year and earns interest
- HSA dollars can be used for eligible health care expenses even if you are no longer enrolled in the HDHP
- HSA dollars can be used to pay for health care expenses (medical, dental, vision, over-the-counter medications) that the IRS considers tax-deductible that are **NOT** covered by any health care plan (see IRS Publication 502 at www.irs.gov)
- HSA accounts can not be combined with a Flexible Spending Account (FSA), but can be combined with a limited flexible spending account. Contact SPA or your employer
- You can contribute additional dollars if you are 55 or older (see IRS Publication 969 at www.irs.gov)

HRA and HSA participation impacts your eligibility and amount of dollars you can contribute to a Flexible Spending Account. Additional information to assist you with understanding the rules and differences can be found on page 22 of this *Decision Guide*.

PPO Option

A Preferred Provider Organization (PPO) allows you to receive benefits from participating in-network and out-of-network providers. In order to receive the highest level of benefit coverage and avoid filing claims and balance billing, you should use an in-network provider. If you choose to use an out-of-network provider, the reimbursement will be at a lower level of benefit coverage. No election of a primary care physician or referral to specialists is required. This option requires you to satisfy a deductible with coinsurance and has an out-of-pocket maximum. When you meet the maximum, the PPO pays your covered services at 100 percent. The PPO option offers you access to a network of more than 13,000 participating physicians and access to every acute care Georgia hospital through the UnitedHealthcare PPO network. You also have the added benefit of access to a national network of participating providers and hospitals across the United States.

Considerations:

- Out-of-network benefits are paid at 60 percent with balance billing
- Co-payments do not apply toward deductibles or out-of-pocket maximum unless otherwise noted
- You must satisfy a separate in-network and out-of-network deductible and separate out-of-pocket maximum

Indemnity Option

If you are currently participating in this option, you may continue to do so in 2008, but this Plan option is not accepting new members. *You will receive a benefits comparison chart in the mail prior to Open Enrollment.*

HMO Options

A Health Maintenance Organization (HMO) allows you to receive benefits from participating providers in the HMO. The SHBP offers BlueCross BlueShield of Georgia Bluechoice HMO, UnitedHealthcare Choice HMO, and Kaiser Permanente HMO. These options are available to SHBP eligible employees who live or work in the county or surrounding counties in which an HMO is offered. You are responsible for selecting a Primary Care Physician (PCP) from a list of participating providers unless you participate in the UnitedHealthcare Choice Option. Your PCP must provide a referral before you see another provider, including specialists, for your expenses to be covered (except in emergencies and other limited cases). If you receive care from a provider other than your PCP, without your PCP's referral, there is no coverage even if the physician or facility is in the HMO network.

HMOs provide 100 percent benefit coverage for preventive health care needs after paying applicable co-payments. Certain services are subject to a deductible and coinsurance amount. *See page 14 for more information.*

Considerations:

- Verify provider participation before selecting an HMO Option
- Coverage is available only when using in-network providers (except in cases of emergencies)
- Diagnostic testing and lab services performed at independent radiology and lab offices located in the Kaiser facilities are subject to deductible and co-insurance

Consumer Choice Options (CCO)

This plan option applies to all SHBP options (except Indemnity) and allows you to nominate (request) a Georgia out-of-network provider to be reimbursed as an in-network provider. This in-network relationship between you and the provider exists only for you and the provider. The out-of-network provider must be licensed and located in Georgia and accept the nomination, fees and conditions of the network and be approved by the network BEFORE you receive any services from that provider. You must also follow this process for each dependent wishing to see an out-of-network provider. For further details and to obtain the necessary paperwork, please call the selected plan option member services department.

Considerations:

- There is no guarantee that the provider you wish to nominate will accept your nomination or be approved by the network
- Similar to the other options, once you choose CCO, you cannot change options until the following OE unless you experience a qualifying event
- The CCO option does not provide enhanced benefits
- Only providers located and licensed in Georgia are eligible for nomination
- Providers may terminate their participation at anytime during the Plan Year

Considerations that Apply to All SHBP Options:

- Annual dollar and visit limitations, deductibles and out-of-pocket spending limits are based on the Plan Year, January 1, 2008 to December 31, 2008
- Lifetime benefit maximums are combined totals among the PPO, HRA, Indemnity, HDHP and HMO Options
- In-network covered services will apply to the in-network deductible and out-of-pocket limit
- A change to the provider network is not a qualifying event and the member may not change Plan options during the Plan Year
- Charges from nonparticipating providers are subject to balance billing. These charges are the member's responsibility and do not count toward deductibles or out-of-pocket spending limits
- Co-payments do not apply toward deductibles or out-of-pocket limits for the Indemnity, PPO and HMO options
- Out-of-network covered services apply to the out-of-network deductible and out-of-pocket limit for the PPO and HDHP. In HMOs, there is no out-of-network coverage, except in limited cases
- Some services may require prior authorization to be covered. Also, some services may have limitations not contained in this summary
- Each Plan offers a Consumer Choice Option (CCO). *See above for details*
- If you are actively working and are covered by a SHBP Plan option, SHBP is always primary if you and/or your spouse are covered by Medicare or TRICARE
- Contact each plan vendor directly for more details regarding covered services, exclusions and limitations. Telephone numbers can be found on the inside cover of this guide

health tip:

To lose weight, burn more calories than you consume each day. Take the stairs instead of the elevator. Instead of watching TV on the weekend, take a walk or ride your bicycle.



SHBP Eligibility

The SHBP covers dependents who meet SHBP guidelines and requires eligibility documentation before SHBP sends dependents' notification of coverage to the health plans.

Eligible dependents are:

- **Your legally married spouse**, as defined by Georgia Law
- **Your never-married dependent children who are:**
 1. **Natural or legally adopted children under age 19**, unless they are eligible for coverage as employees. Children that are legally adopted through the judicial courts become eligible only after they are placed in your physical custody
 2. **Stepchildren under age 19 who live with you** at least 180 days per year and for whom you can provide documentation satisfactory to the Plan that they are your dependents
 3. **Other children under age 19** if they live with you permanently and legally depend on you for financial support – as long as you have a court order, judgment or other satisfactory proof from a court of competent jurisdiction
 4. **Your natural children, legally adopted children or stepchildren who were covered under the SHBP before age 19 from categories 1 and 2 above** who are physically or mentally disabled prior to reaching age 19 and who depend on you for primary support may continue their existing Plan coverage past age 19
 5. **Your natural children, legally adopted children, stepchildren or other children ages 19 through 25 from categories 1, 2, or 3 above** who are registered full-time students at fully accredited schools, colleges, universities or nurse training institutions and, if employed, who are not eligible for a medical benefit plan from their employer. The number of credit hours required for full-time student status is defined by the school in which the child is enrolled

Making Changes When You Have a Qualifying Event

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

Qualifying events include, but are not limited to:

- Birth or adoption of a child or placement for adoption
- Change in residence by you, your spouse or dependents that results in ineligibility for coverage in your selected option because of location
- Death of a spouse or child, if the only dependent enrolled
- Your spouse's or dependent's loss of eligibility for other group health coverage
- Marriage or divorce
- Medicare eligibility

Documentation Confirming Eligibility for Your Spouse or Dependents

- **Spouse:** A copy of your certified marriage certificate or a copy of your most recent Federal Tax Return (filed jointly with spouse) including legible signatures for you and your spouse with financial information blacked out
- **Natural or student child:** A copy of the certified birth certificate listing the parents by name or a letter of confirmation of birth for newborns. Birth cards without the parents' names are not acceptable
- For students age 19 through age 25, SHBP requires the child's birth certificate and documentation from the school's registrar's office verifying full-time student status
- **Stepchild:**
 1. A copy of the certified birth certificate showing your spouse is the natural parent;
 2. A copy of the certified marriage certificate showing the natural parent is your spouse; and
 3. A notarized statement that the dependent lives in your home at least 180 days per year

You have 31 days from the date of the qualifying event or the day of the request for coverage, whichever is later, to provide the qualifying event documentation and/or dependent verification documentation.

The member's social security number **MUST** be written on each document so we can match your dependents to your record. Do not send originals as originals will not be returned.

health tip:

As much as 25 percent of any weight loss may come from muscle. Weight lifting will build muscle increasing your metabolism. Muscle keeps your metabolism revved up burning calories, fat and sugar.



Benefits Comparison

Schedule of Benefits for You and Your Dependents for January 1, 2008 – December 31, 2008

Covered Services	PPO OPTION		HRA OPTION	
	In-network	Out-of-network	In-network Definity or Lumenos	Out-of-network Definity or Lumenos
	<i>The Plan Pays:</i>		<i>The Plan Pays:</i>	
Maximum Lifetime Benefit (combined for all SHBP Options)	\$2 million		\$2 million	
Pre-Existing Conditions (First year in Plan only, subject to HIPAA)	\$1,000		None	
Lifetime Benefit Limit for Treatment of: (combined for PPO Option and HDHP) <ul style="list-style-type: none"> • Temporomandibular joint dysfunction (TMJ) • Substance abuse 	\$1,100	3 episodes	\$1,100	3 episodes
Deductibles/Co-Payments: <ul style="list-style-type: none"> • Deductible—individual • Deductible—family maximum 	\$500 \$1,500	\$600 \$1,800	\$1,000* \$2,000* <i>*HRA credits will reduce this amount.</i>	
<ul style="list-style-type: none">• Hospital deductible per admission	\$250		Not applicable	
Annual Out-of-pocket Limits: <ul style="list-style-type: none"> • Individual • Family 	\$1,100 \$2,200	\$2,200 \$4,400	\$2,000* \$4,000* <i>*HRA credits will reduce this amount.</i>	
HRA Credits: <ul style="list-style-type: none"> • Individual • Family combined 	None		\$500* \$1000* <i>*un-used credits roll to next plan year.</i>	
Physicians' Services				
Primary Care Physician or Specialist Office or Clinic Visits: Treatment of illness or injury	100% after a \$30 per office visit co-payment; not subject to deductible	60% coverage; subject to deductible	90% coverage; subject to deductible	60% coverage; subject to deductible
Primary Care Physician or Specialist Office or Clinic Visits for the Following: <ul style="list-style-type: none"> • Wellness care/preventive health care • Annual gynecological exams (these services are not subject to the deductible) 	100% after \$30 co-payment per office visit. No co-payment for associated tests and immunizations. Maximum of \$1000 per person per Plan Year.	Not covered. Charges do not apply to deductible or annual out-of-pocket limits.	100% coverage; not subject to deductible	Not covered. Charges do not apply to deductible or annual out-of-pocket limits.
Maternity Care (prenatal, delivery and postpartum)	90% coverage; not subject to deductible after initial \$30 co-payment	60% coverage; subject to deductible	90% coverage; subject to deductible	60% coverage; subject to deductible

Dollar amounts, visit limitations, deductibles and out-of-pocket limits are based on a January 1 – December 31, 2008 Plan Year. NOTE: Coverage is defined as allowed eligible expenses. Exclusions and limitations vary among Plan options. Contact your specific Plan option for more information.

HIGH DEDUCTIBLE OPTION (HDHP)		HMO OPTIONS	
In-network	Out-of-network	BlueChoice, Kaiser Permanente, UnitedHealthcare	
<i>The Plan Pays:</i>		<i>The Plan Pays:</i>	<i>HMO Plan Differences:</i>
\$2 million		\$2 million	
None		None	
\$1,100 3 episodes		No separate lifetime benefit limit	
\$1,100 \$2,200*	\$2,200 \$4,400*	\$200 \$400	
<i>*You must meet the family deductible before benefits are payable for any family member.</i>			
Not applicable		Not applicable	
\$1,700 \$2,900	\$3,800 \$7,000	\$1,000 \$2,000	
None		None	
90% coverage; subject to deductible	60% coverage; subject to deductible	100% after a per visit co-payment** of \$20 for primary care and \$25 for specialty care	**Includes lab and x-rays done in the physician's office. Kaiser – lab and x-rays may be subject to deductible.
100% coverage; not subject to deductible	Not covered. Charges do not apply to deductible or annual out-of-pocket limits.	100% after a per visit co-payment of \$20 for primary care and \$25 for specialty care. No co-payment for immunizations and mammograms.	No primary care physician designation or specialist referral for UHC.
90% coverage; subject to deductible	60% coverage; subject to deductible	100% after initial \$25 co-payment	

	PPO OPTION		HRA OPTION	
	In-network	Out-of-network	In-network Definity or Lumenos	Out-of-network Definity or Lumenos
Physicians' Services				
<i>The Plan Pays:</i>				
Physician Services Furnished in a Hospital • Visits; surgery in general, including charges by surgeon, anesthesiologist, pathologist and radiologist	90% coverage; subject to deductible	60% coverage; subject to deductible	90% coverage; subject to deductible	60% coverage; subject to deductible
Physician Services for Emergency Care Non-emergency use of the emergency room not covered	90% coverage; subject to deductible	90% coverage; subject to in-network deductible	90% coverage; subject to deductible	90% coverage; subject to deductible
Outpatient Surgery— • When billed as office visit	90% coverage; subject to deductible	60% coverage; subject to deductible	90% coverage; subject to deductible	60% coverage; subject to deductible
• When billed as outpatient surgery at a facility	90% coverage; subject to deductible	60% coverage; subject to deductible	90% coverage; subject to deductible	60% coverage; subject to deductible
Allergy Shots and Serum	100% for shots and serum; \$30 per visit co-payment not subject to deductible (no co-payment if office visit not billed)	60% coverage; subject to deductible	90% coverage; subject to deductible	60% coverage; subject to deductible
Hospital Services				
Inpatient Services • Inpatient care, delivery and inpatient short-term acute rehabilitation services	90% coverage after deductible; and subject to a \$250 per admission deductible	60% coverage after deductible; and subject to a \$250 per admission deductible	90% coverage; subject to deductible	60% coverage; subject to deductible
• Well-newborn care	100% coverage; not subject to deductible	60% coverage; not subject to deductible	90% coverage; subject to deductible	60% coverage; subject to deductible
Outpatient Surgery— Hospital/facility	90% coverage; subject to deductible	60% coverage; subject to deductible	90% coverage; subject to deductible	60% coverage; subject to deductible
Emergency Care—Hospital • Treatment of an emergency medical condition or injury • Non-emergency use of the emergency room not covered	90% coverage after a \$100 per visit co-payment; co-payment waived if admitted; subject to in-network deductible	90% coverage after a \$100 per visit co-payment; co-payment waived if admitted; subject to in-network deductible	90% coverage; subject to deductible	
Outpatient Testing, Lab, etc.				
Laboratory; X-Rays; Diagnostic Tests; Injections— including medications covered under medical benefits—for the treatment of an illness or injury	90% coverage; subject to deductible	60% coverage; subject to deductible	90% coverage; subject to deductible	60% coverage; subject to deductible

HIGH DEDUCTIBLE OPTION		HMO OPTIONS	
In-network	Out-of-network	BlueChoice, Kaiser Permanente, UnitedHealthcare	
<i>The Plan Pays:</i>		<i>The Plan Pays:</i>	<i>HMO Plan Differences:</i>
90% coverage; subject to deductible	60% coverage; subject to deductible	90% coverage; subject to deductible	
90% coverage; subject to deductible	90% coverage; subject to deductible	100% (\$100 co-pay applies to facility expenses)	Non-emergency use of the emergency room not covered. Applies to all plan options.
90% coverage; subject to deductible	60% coverage; subject to deductible	100% after \$20 co-payment for PCP, \$25 for specialist, if billed as office visit	Kaiser Permanente – 90% coverage; subject to deductible
90% coverage; subject to deductible	60% coverage; subject to deductible	90% coverage; subject to deductible	
90% coverage; subject to deductible	60% coverage; subject to deductible	100% for shots and serum after a \$25 per visit co-payment	Kaiser Permanente – \$5 for shots and \$50 for a three-month supply of serum. UnitedHealthcare – no co-pay if office visit not billed.
90% coverage; subject to deductible	60% coverage; subject to deductible	90% coverage; subject to deductible	
90% coverage; subject to deductible	60% coverage; subject to deductible	100% coverage not subject to deductible	
90% coverage; subject to deductible	90% coverage; subject to deductible	90% coverage; subject to deductible	
90% coverage; subject to deductible	90% coverage; subject to deductible	100% after a \$100 per visit co-payment; co-payment waived if admitted; subject to deductible	Non-emergency use of the emergency room not covered. Applies to all plan options.
90% coverage; subject to deductible	60% coverage; subject to deductible	90% coverage; subject to deductible	Kaiser Permanente – lab and x-rays may be subject to deductible. UnitedHealthcare – independent lab/x-ray are payable at 100%.

	PPO OPTION		HRA OPTION	
	In-network	Out-of-network	In-network Definity or Lumenos	Out-of-network Definity or Lumenos
Behavioral Health	<i>The Plan Pays:</i>		<i>The Plan Pays:</i>	
Mental Health and Substance Abuse Inpatient Facility NOTE: All services require prior authorization.	90% coverage; subject to deductible; limited to 45 days combined per Plan Year (includes any out-of-network visits)	60% coverage; subject to deductible; limited to 45 days combined per Plan Year (includes any in-network visits)	90% coverage; subject to deductible limited to 30 days combined per Plan Year	60% coverage; subject to deductible limited to 30 days combined per Plan Year
Partial Day Hospitalization and Intensive Outpatient NOTE: Notification required. (Mental Health and Substance Abuse)	90% coverage; subject to deductible; limited to 60 days combined per Plan Year (includes any out-of-network visits)	No benefit	90% coverage; subject to deductible; limited to 30 days combined per Plan Year	60% coverage; subject to deductible; limited to 30 days combined per Plan Year
Professional Charges Inpatient (Mental Health and Substance Abuse)	90% coverage; subject to deductible; limited to 1 visit per authorized day combined per Plan Year (includes any out-of-network visits)	60% coverage; subject to deductible; limited to 1 visit per authorized day combined per Plan Year (includes any in-network visits)	90% coverage; subject to deductible; limited to 30 visits per authorized day combined per Plan Year	60% coverage; subject to deductible; limited to 30 visits per authorized day combined per Plan Year
Mental Health and Substance Abuse Outpatient Visits NOTE: Notification required.	90% coverage; subject to deductible; limited to 50 visits per Plan Year (the 50 visit limit includes any out-of-network visits)	60% coverage; subject to deductible; limited to 25 visits per Plan Year (not to exceed a total of 50 visits combined)	90% coverage; subject to deductible; limited to 30 visits per Plan Year (includes any out-of-network visits)	60% coverage; subject to deductible; limited to 30 visits per Plan Year (includes any in-network visits)
Dental				
Dental and Oral Care NOTE: Coverage for most procedures for the prompt repair of sound natural teeth or tissue for the correction of damage caused by traumatic injury.	90% coverage; subject to deductible	60% coverage; subject to deductible	90% coverage; subject to deductible	60% coverage; subject to deductible
	----- NOTE: Notification required for all UHC options.			
Temporomandibular Joint Syndrome (TMJ) NOTE: Coverage for diagnostic testing and non-surgical treatment up to \$1,100 per person lifetime maximum benefit. This limit does not apply to the HMO.	90% coverage; subject to deductible	60% coverage; subject to deductible	90% coverage; subject to deductible	60% coverage; subject to deductible
Vision				
Routine Eye Exam	90% coverage; not subject to deductible; limited to one eye exam every 24 months	Eye exam not covered	Contact HRA vendor directly for more information	
Other Coverage				
Ambulance Services for Emergency Care NOTE: "Land or air ambulance" to nearest facility to treat the condition.	90% coverage; subject to deductible	90% coverage; subject to deductible	90% coverage; subject to deductible	90% coverage; subject to deductible

HIGH DEDUCTIBLE OPTION		HMO OPTIONS	
In-network	Out-of-network	BlueChoice, Kaiser Permanente, UnitedHealthcare	
<i>The Plan Pays:</i>		<i>The Plan Pays:</i>	<i>HMO Plan Differences:</i>
90% coverage; subject to deductible limited to 30 days combined per Plan Year (includes any out-of-network visits)	60% coverage; subject to deductible limited to 30 days combined per Plan Year (includes any in-network visits)	90% coverage; not subject to deductible and limited to 30 days combined per Plan Year	Kaiser Permanente – 90% coverage; subject to deductible and unlimited days for mental health; 30-day limit for substance abuse
90% coverage; subject to deductible limited to 60 days combined per Plan Year (includes any out-of-network visits)	60% coverage; subject to deductible limited to 30 days combined per Plan Year (includes any in-network visits)	Each HMO may or may not offer this benefit; contact the HMO for more information	
90% coverage; subject to deductible limited to 1 visit per authorized day combined per Plan Year (includes any out-of-network visits)	60% coverage; subject to deductible limited to 1 visit per authorized day combined per Plan Year (includes any in-network visits)	90% coverage; not subject to deductible	Kaiser Permanente – 90% coverage; subject to deductible
90% coverage; subject to deductible limited to 50 visits combined per Plan Year (includes any out-of-network visits)	60% coverage; subject to deductible limited to 25 visits combined per Plan Year (includes any in-network visits)	100% after \$25 per visit co-payment; limited to 25 visits per Plan Year	
90% coverage; subject to deductible	60% coverage; subject to deductible	100% after applicable co-payment, if inpatient/outpatient facility; subject to deductible	Contact the respective vendor
90% coverage; subject to deductible	60% coverage; subject to deductible	100% after applicable co-payment for related surgery and diagnostic services; excludes appliances and orthodontic treatment; if inpatient/outpatient facility, 90% subject to deductible	Kaiser Permanente – 50% for non-surgical treatment; excludes appliances and orthodontic treatment; if inpatient/outpatient facility; 90% subject to deductible
90% coverage; not subject to deductible; limited to one eye exam every 24 months	Eye exam not covered	Contact HMO directly for more information	UHC includes \$200 benefit for glasses and contacts
90% coverage; subject to deductible	90% coverage; subject to deductible	100%	Kaiser Permanente – 100% after a \$50 per trip co-payment when medically necessary.

	PPO OPTION		HRA OPTION	
	In-network	Out-of-network	In-network Definity or Lumenos	Out-of-network Definity or Lumenos
Other Coverage	<i>The Plan Pays:</i>		<i>The Plan Pays:</i>	
Urgent Care Services	90% coverage after a \$45 per visit co-payment; subject to deductible	60% coverage; subject to deductible	90% coverage; subject to deductible	60% coverage; subject to deductible
Home Health Care Services NOTE: Prior approval required	90% coverage; subject to deductible	60% coverage; subject to deductible	90% coverage; subject to deductible	60% coverage; subject to deductible
Skilled Nursing Facility Services NOTE: Prior approval required	90% coverage after deductible; up to 120 days per Plan Year; subject to a \$250 per admission deductible	Not covered	90% coverage; up to 120 days per Plan Year	Not covered
Hospice Care NOTE: Prior approval required	100% coverage; subject to deductible	60% coverage; subject to deductible	90% coverage; subject to deductible	60% coverage; subject to deductible
Durable Medical Equipment (DME)—Rental or purchase	90% coverage; subject to deductible (UHC options require notification over \$1000)	60% coverage; subject to deductible	90% coverage; subject to deductible	60% coverage; subject to deductible
Outpatient Acute Short-Term Rehabilitation Services <ul style="list-style-type: none"> • Physical Therapy • Speech Therapy • Occupational Therapy • Other short term rehabilitative services 	90% coverage; subject to deductible; \$20 per visit co-payment up to 40 visits per Plan Year (not to exceed a total of 40 visits combined, including any out-of-network visits)	60% coverage; subject to deductible; up to 40 visits per Plan Year (not to exceed a total of 40 visits, including any in-network visits)	90% coverage; subject to deductible; up to 40 visits per Plan Year (not to exceed a total of 40 visits combined, including any out-of-network visits)	60% coverage; subject to deductible; up to 40 visits per Plan Year (not to exceed a total of 40 visits combined, including any in-network visits)
Chiropractic Care NOTE: Coverage for up to a maximum of 20 visits per Plan Year.	90% coverage; after a \$30 per visit co-payment; not subject to deductible	60% coverage; subject to deductible	90% coverage; subject to deductible	60% coverage; subject to deductible
Transplant Services NOTE: Prior approval required. Lumenos lifetime benefit maximum \$500,000 (except for kidney or cornea).	90% coverage at contracted transplant facility; subject to deductible and \$250 per admission deductible	Not covered	90% coverage; subject to deductible	60% coverage; subject to deductible
Pharmacy				
Tier 1 Co-payment NOTE: No Tiers in HRA Option	\$10	\$10*	90% coverage; subject to deductible	60% coverage; subject to deductible
Tier 2 Co-payment	\$30	\$30*		
Tier 3 Co-payment	\$100	\$100*		

*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. Member is responsible for charges that exceed the pharmacy network rate.

HIGH DEDUCTIBLE OPTION		HMO OPTIONS	
In-network	Out-of-network	BlueChoice, Kaiser Permanente, UnitedHealthcare	
<i>The Plan Pays:</i>		<i>The Plan Pays:</i>	<i>HMO Plan Differences</i>
90% coverage; subject to deductible	60% coverage; subject to deductible	100% after \$25 co-payment	BlueChoice – referral required. Kaiser Permanente – 100% after \$30 co-payment
90% coverage; subject to deductible	60% coverage; subject to deductible	100% coverage; up to 120 visits per Plan Year	
90% coverage up to 120 days per Plan Year; subject to deductible	Not covered	90% coverage; up to 120 days per Plan Year; subject to deductible	Kaiser Permanente – up to 60 days per Plan Year; subject to deductible
90% coverage; subject to deductible	60% coverage; subject to deductible	100% coverage; subject to deductible	
90% coverage; subject to deductible	60% coverage; subject to deductible	100% coverage when medically necessary	UnitedHealthcare – notification required for items over \$1,000
90% coverage up to 40 visits per Plan Year; subject to deductible (not to exceed a total of 40 visits combined, including any out-of-network visits)	60% coverage up to 40 visits per Plan Year; subject to deductible (not to exceed a total of 40 visits combined, including any in-network visits)	100% coverage after \$25 per visit co-payment; up to 40 visits per Plan Year	
90% coverage; subject to deductible	60% coverage; subject to deductible	100% coverage after \$25 co-payment per visit	
90% coverage at contracted transplant facility; subject to deductible	Not covered	90% coverage; subject to deductible	
80% coverage; subject to deductible \$10 min./\$100 max.	60% coverage; subject to deductible \$10 min./\$100 max.	\$10	Kaiser Permanente – Kaiser facility: \$10 Network Pharmacies: \$16
80% coverage; subject to deductible \$10 min./\$100 max.	60% coverage; subject to deductible \$10 min./\$100 max.	\$25	Kaiser Permanente – Kaiser facility: \$25 Network Pharmacies: \$31
80% coverage; subject to deductible \$10 min./\$100 max.	60% coverage; subject to deductible \$10 min./\$100 max.	\$50	Kaiser Permanente – N/A

HRA, HSA and Flexible Spending Account Considerations

	HRA	HSA
Overview	<p>A tax-exempt account that reimburses employees and dependents for qualified medical expenses. Can be funded by employer only.</p> <p>-----</p> <p>Available to SHBP members enrolled in an HRA.</p>	<p>A tax-exempt custodial account that exclusively pays for qualified medical expenses of the employee and his or her dependents. Can be funded by employee, employer, or other party.</p> <p>-----</p> <p>Available to SHBP members who elect HDHP. An HSA is available under the Flexible Benefits Program, your employer or you may participate as an individual.</p>
Can I have other coverage and take advantage of this benefit?	Yes.	No other general medical insurance coverage permitted. You cannot be enrolled in Medicare Part A or Part B.
Can I participate in a FSA?	You may enroll in a General Purpose FSA. You may use a Flexible Spending Account (FSA) for uncovered or unreimbursed portions of qualified medical costs.	You may enroll in a Limited Purpose FSA if you are enrolled in a HSA.
Who owns the money in these accounts?	SHBP. Money reverts back to SHBP upon loss of SHBP HRA coverage.	The employee.
Can these dollars be rolled over each year?	Yes.	Yes.
Is there a monthly service charge?	No.	Yes, \$3.00 per account per month with the SPA Flexible Benefits Program. For other HSA accounts check with your HSA administrator.
What is the order in using these accounts?	HRA must be used before using the FSA.*	Can only use Limited Purpose FSA with the HSA, but it doesn't matter which is used first.
Can I take it with me?	Unused amounts can be distributed until depleted to pay for claims incurred before termination.	Fund disbursement is not tied to individual's employment. Unused amounts can be distributed tax-free for qualified medical expenses. Subject to income and excise tax for non-qualified expenses.

*When determining how much money to set aside in an FSA, employees should consider the first \$500 (single) or \$1,000 (family) of qualified medical expenses will be covered by the HRA.

If You Are Retiring... What You Need to Know

State Health Benefit Plan Medicare Policy

If you want to have health insurance under SHBP when you retire, you must enroll for coverage for you and any eligible dependents during the OE period prior to your retirement.

Once retired, you will have an annual Retiree Option Change Period that allows you to change your Plan option only. You may add dependents only if you experience a qualifying event and request the change within 31 days and provide the documentation required by SHBP.

The following information and “Important Notices about Your Prescription Drug Coverage and Medicare” are provided to assist you with Retirement Planning. See pages 24–27.

Federal Law requires SHBP to pay primary benefits for active employees and their dependents. Active members or their covered dependents may choose to delay Medicare enrollment. Termination of active employment is a qualifying event for enrolling in Medicare without penalty. *Except HDHP, see page 24.*

1. SHBP calculates premiums and claims payments based upon Medicare enrollment for retirees over age 65 or those eligible for Medicare due to disability. SHBP will coordinate benefits for members who are enrolled for Medicare Parts A, B and/or D. Premiums will be reduced for each part of Medicare for which the retiree enrolls after you notify SHBP of your Medicare enrollment. Premiums are not reduced retroactive to the date of enrollment for failure to notify SHBP at the time of enrollment
2. SHBP will pay primary benefits for non-enrolled Medicare eligible retirees as well as retirees who are not entitled to Medicare because they did not participate in Social Security or pay Medicare taxes. The premiums for these primary payments will be increased the month in which the retiree (or dependent spouse) reaches 65 or becomes eligible for Medicare due to disability

Members who are enrolled in Medicare due to End State Renal Disease (ESRD) will need to contact the Social Security Administration to determine when Medicare becomes primary.

Additional Information Concerning Medicare Part D

If you are eligible and/or enrolled in Medicare Part A or Part B, you are eligible for Part D. SHBP provides secondary coverage to Medicare prescription drug plans. In many cases, the member does not need the enhanced prescription drug plan. Your individual pharmacy needs will determine the level of coverage that is best for you.

If you are retiring and enroll in the Kaiser Permanente Senior Advantage (MAPD) Option, you do not need to join an individual Medicare Part D plan as the Senior Advantage Option is a Medicare Part D Plan and coordinates benefits with all parts of Medicare.

If you elect to enroll in another Medicare Part D plan, your coverage in the MAPD plan through Kaiser Permanente will end. To enroll in the Kaiser MAPD, you must make your election on the Personalized Change Form and submit to SHBP. Kaiser will mail you a Senior Advantage application that you will need to complete. Please request this form by calling (404) 233-3700.



health tip:

You can lose weight with a modest amount of exercise. Daily exercise of 30 minutes or more; whether two 15 minutes, three 10 minutes or 30 minutes.



GEORGIA DEPARTMENT OF
COMMUNITY HEALTH

Two Peachtree Street
Atlanta, GA 30303
(404) 656-6322 • (800) 610-1863

October 1, 2007

Important Notice from the SHBP for Medicare Eligible Members

About Your Prescription Drug Coverage with BlueChoice HMO, BlueCross BlueShield Lumenos HRA, Kaiser Permanente, Indemnity, PPO, UnitedHealthcare Choice HMO, UnitedHealthcare Definity HRA and Medicare

For Plan Year: January 1–December 31, 2008

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with the SHBP and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. The SHBP has determined that the prescription drug coverage offered by BlueChoice HMO, BlueCross BlueShield Lumenos HRA, Kaiser Permanente, Indemnity, PPO, UnitedHealthcare Choice HMO and UnitedHealthcare Definity HRA Options under SHBP are, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is considered Creditable Coverage.

Because your existing coverage is, on average, at least as good as standard Medicare prescription drug coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

You can join a Medicare drug plan when you first become eligible for Medicare and each year from November 15th through December 31st. This may mean that you may have to wait to join a Medicare drug plan and that you may pay a higher premium (a penalty) if you join later. You may pay that higher premium (a penalty) as long as you have Medicare prescription drug coverage. However, if you lose creditable prescription drug coverage, through no fault of your own, you will be eligible for a sixty (60) day Special Enrollment Period (SEP) because you lost creditable coverage to join a Part D plan. In addition if you lose your SHBP coverage, you will be eligible to join a Part D plan at that time using an Employer Group Special Enrollment Period. You should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area.

If you decide to join a Medicare drug plan, your SHBP coverage will be affected. See below for more information about what happens to your current coverage if you join a Medicare drug plan.

If you elect Part D and keep your SHBP coverage under BlueChoice HMO, BlueCross BlueShield Lumenos HRA, Kaiser Permanente, Indemnity, PPO, UnitedHealthcare Choice HMO and UnitedHealthcare Definity HRA Options, these plans will coordinate with Part D coverage.

If you do decide to join a Medicare drug plan and drop your BlueChoice HMO, BlueCross BlueShield Lumenos HRA, Kaiser Permanente, Indemnity, PPO, UnitedHealthcare Choice HMO or UnitedHealthcare Definity HRA coverage, be aware that you and your dependents will not be able to get your SHBP coverage back if you are a retiree. You should also know that if you drop or lose your coverage with SHBP and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without prescription drug coverage that's at least as good as Medicare's prescription drug coverage, your monthly premium may go up by at least 1% of the base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without coverage, your premium may consistently be at least 19% higher than the base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following November to join.

For More Information about this Notice or Your Current Prescription Drug Coverage...

Contact the SHBP Call Center at (404) 656-6322 or (800) 610-1863 for further information. NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if your SHBP coverage changes. You also may request a copy.

For More Information about Your Options under Medicare Prescription Drug Coverage...

More detailed information about Medicare plans that offer prescription drug coverage is in the *Medicare & You* handbook. You will get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans. For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the *Medicare & You* handbook for their telephone number) for personalized help
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and whether or not you are required to pay a higher premium (a penalty).

Date: October 1, 2007

Name of Entity/Sender: State Health Benefit Plan

Office: Call Center

Address: P. O. Box 38342, Atlanta, GA 30334

Phone Number: (404) 656-6322 or (800) 610-1863



GEORGIA DEPARTMENT OF
COMMUNITY HEALTH

Two Peachtree Street
Atlanta, GA 30303
(404) 656-6322 • (800) 610-1863

October 1, 2007

Important Notice from the SHBP for Medicare Eligible Members

About Your Prescription Drug Coverage with the High Deductible Health Plan and Medicare

For Plan Year: January 1–December 31, 2008

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with the State Health Benefit Plan (SHBP) and about your options under Medicare's prescription drug coverage. This information can help you decide whether you want to join a Medicare drug plan. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium
2. **The SHBP has determined that the prescription drug coverage under the High Deductible Health Plan (HDHP) Option, is, on average for all plan participants, NOT expected to pay out as much as standard Medicare prescription drug coverage pays and is considered Non-Creditable Coverage. This is important, because most likely, you will get more help with your drug costs if you join a Medicare drug plan, than if you only have prescription drug coverage through the HDHP offered by the SHBP**
3. You have decisions to make about Medicare prescription drug coverage that may affect how much you pay for that coverage, depending on if and when you join. Read this notice carefully as it explains your options

Consider joining a Medicare drug plan. You can keep your HDHP coverage offered by the SHBP. You can keep the coverage regardless of whether it is as good as Medicare drug plan. However, because your existing coverage is, on average, NOT at least as good as standard Medicare prescription drug coverage, you may pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

You can join a Medicare drug plan when you first become eligible for Medicare and each year from November 15th through December 31st. This may mean that you may have to wait to join a Medicare drug plan and that you may pay a higher premium (a penalty) if you join later. You may pay that higher premium (a penalty) as long as you have Medicare prescription drug coverage. However, if you lose your HDHP coverage under the SHBP; you will be eligible to join a Part D plan at that time using an Employer Group Special Enrollment Period.

You Need to Make a Decision

When you make your decision, you should compare your current coverage, including which drugs are covered, with the coverage and cost of the plans offering Medicare prescription drug coverage in your area. If you decide to join a Medicare drug plan, your HDHP coverage under SHBP will be affected. See below for more information about what happens to your current coverage if you join a Medicare drug plan.

If you enroll in Medicare Part D when you become eligible for Medicare Part D, you can keep your HDHP coverage even if you elect Part D and the HDHP will coordinate benefits with Part D coverage.

If you do decide to join a Medicare drug plan and drop your HDHP coverage under SHBP, be aware that you and your dependents will not be able to get your SHBP coverage back if you are a retiree.

You should also know that if you drop or lose your HDHP coverage with SHBP and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without prescription drug coverage that's at least as good as Medicare's prescription drug coverage, your monthly premium may go up by at least 1% of the base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without coverage, your premium may consistently be at least 19% higher than the base beneficiary premium. You may have to pay this higher premium (penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following November to join.

For More Information about this Notice or Your Current Prescription Drug Coverage...

Contact the SHBP Call Center at (404) 656-6322 or (800) 610-1863 for further information.

NOTE: You will get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if your SHBP coverage changes. You also may request a copy.

For More Information about Your Options under Medicare Prescription Drug Coverage...

More detailed information about Medicare plans that offer prescription drug coverage is in the *Medicare & You* handbook. You will get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans. For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the *Medicare & You* handbook for their telephone number) for personalized help
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Date: October 1, 2007

Name of Entity/Sender: State Health Benefit Plan

Office: Call Center

Address: P. O. Box 38342, Atlanta, GA 30334

Phone Number: (404) 656-6322 or (800) 610-1863

Notes





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COMMUNITY HEALTH