ACTIVE EMPLOYEE

State Health Benefit Plan
DECISION GUIDE 2007

Georgia

OPEN ENROLLMENT
October 10 - November 9, 2006

Phone Numbers/Contact Information

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

PPO, PPO CCO, Indemnity:

Member Services	877-246-4189 TDD 800-955-8770
To View Benefit Video	www.myuhc.com/groups/gdch
Pharmacy Information	877-650-9342 TDD 800-842-5754

HDHP:

Member Services and Pharmacy	877-246-4195 TDD 800-842-5754

HMOs:

BlueChoice	800-464-1367 TDD 404-842-8073	www.bcbsga.com
Cigna	800-564-7642	www.cigna.com
Kaiser Permanente	800-611-1811 TDD 800-255-0056	www.kaiserpermanente.org
United Healthcare	866-527-9599 TDD 800-955-8770	www.myuhc.com/groups/gdch
TRICARE Supplement:	800-638-2610 ext. 255	www.asitrisuppga.com
All Options: Eligibility	404-656-6322 or 800-610-1863	

Page 4 of this Guide contains Plan changes effective January 1, 2007. Prior to the start of the 2007 Plan Year, 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, 2007. 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.

Welcome

Welcome to Open Enrollment for the State Health Benefit Plan for Coverage effective January 1, 2007 – December 31, 2007

This guide will provide you with a brief explanation of each Plan Option, steps on how to make your Open Enrollment election, information about the Health & Wellness features available through the health plan options and a comparison of benefits chart. The Decision Guide for Active Employees can be found at www.dch.georgia.gov/shbp_plans or www.oe2007ga.gov.

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SHBP Plan Options

High Deductible Health Plan PPO (HDHP) • BlueChoice HMO • Indemnity Plan • CIGNA HMO • UHC Preferred Provider Organization (PPO) • Kaiser HMO • TRICARE Supplement *(see page 11 for eligibility rules)* • United Healthcare Choice HMO

Consumer Choice Options (CCO): For a higher premium, the PPO, HMO and High Deductible Health Plan options allow a member to nominate a Georgia out-of-network provider. If approved, the member may receive services from the provider at the in-network benefit level.

Am I Eligible to Participate in Each of the Above Options?

All employees are eligible to participate in the HDHP, Indemnity and PPO options. You may participate in the Kaiser HMO only if you live or work in the metro Atlanta area. You may participate in the other HMOs if the HMO is offered in the county where you live or work or you are willing to drive to a county where the HMO is offered. You may participate in the TRICARE Supplement only if you are eligible for TRICARE and have a Defense Enrollment Eligibility Reporting System (DEERS) number.

Open Enrollment

Who Must Participate in Open Enrollment?

EVERYONE who wants to:

- Continue health coverage
- Enroll for health coverage
- Change health coverage options
- Add or drop eligible dependents
- Discontinue coverage

What Should I Do before I Go On-line for Open Enrollment?

- Read the Decision Guide available from your payroll office or available at www.dch.georgia.gov/shbp_plans or www.oe2007.ga.gov
- Read the Summary Plan Description (SPD) available at www.dch.georgia.gov/shbp_plans
- Use the Plan Cost Estimator available at www.dch.georgia.gov/shbp_plans
- Check rates with your employer or at www.dch.georgia.gov/shbp_plans
- Call each Plan Option or go to the vendor website to see in which Option your physician or provider participates
- Check Tier 1, 2 & 3 drug lists with each Plan Option

Go online at www.oe2007.ga.gov October 10–November 9, 2006 to complete Open Enrollment. It's fast, easy, and secure!

Follow These Steps to Make Your On-line Open Enrollment Selections:

1. Go to www.oe2007.ga.gov. You will have to "register" the first time you logon. Click on Register and enter your Policy Number and Date of Birth. Select a Password and enter the password, re-enter the password to confirm, select a security question and answer your security answer. You then click on "register". This will take you to the "login" screen. Here you will enter your Policy Number, Password and then click on "login". This will take you to the Terms of Use. After you scroll to the bottom, click and agree to the authorization...then click on agree, your current health benefit election will appear. If you have technical difficulty in logging in, contact the Help Desk toll free at 1 (866) 676-0009.
2. Your 2006 Health Benefit election and covered dependents will be listed. Make any necessary changes.
3. Prior to confirming your benefits, review to make sure your benefits election, covered dependents and answers to the surcharge questions are correct. If your selection is not correct, go back and make changes. You may return to the website as often as you wish during the Open Enrollment period to make changes.
4. Print your confirmation notice to confirm your enrollment. Each time you login the system and confirm your choices, you will receive a new unique confirmation number which you should print. You should keep the confirmation notice in your records. The benefits selected and confimed as of 4:00 p.m. November 9, 2006 will be your benefit selection for the 2007 plan year.

If you participate in Georgia Merit System Flexible Benefits Program

www.oe2007.ga.gov will be used for making all of your benefit elections in the Flexible Benefit options including health insurance. You will need to obtain two confirmation numbers: (1) for the Flexible Benefits options and (2) for your health insurance selection. **It is important to print or write down both confirmation numbers and keep this information for your records.** After Open Enrollment has ended, you will receive a paper confirmation statement containing all of your selections. Please compare this information with the pages you printed from the website to ensure accuracy. See the *You Decide!* Booklet for web navigation instructions.

If you are employed by a Board of Education or other agency and NOT a Georgia Merit System Flexible Benefits Program participant:

You will need to obtain a confirmation number in order for your selection to be valid. Please print or write down the confirmation number and keep this information for your records. Contact your personnel/payroll office to obtain information regarding your other benefits.

What Happens if I don't Go On-line?

You will retain the same coverage option and tier (single or family) you currently have but will automatically be assessed the tobacco surcharge and the spousal surcharge (if your spouse is covered). You will pay these surcharges for all of the 2007 Plan Year unless you experience a qualifying event.

If you and your spouse each have SHBP coverage because of employment, you each must make an Open Enrollment election for each contract!

DCH Surcharge Policy

Spousal Surcharges

A 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 chose not to take it. 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 answer all questions concerning the surcharge. The surcharge will apply to your premium for Plan Year 2007.

Tobacco Surcharge

A tobacco surcharge will be added to your monthly premium for Plan Year 2007 if you or any of your covered dependents have used tobacco products in the previous twelve months. The tobacco surcharge may removed by completing the tobacco cessation requirements. Details are on page 22 and on the Department of Community Health website, www.dch.georgia.gov/shbp_plans.

health tip:

Kick the smoking habit. Many serious health risks are associated with smoking, including heart disease and elevated blood pressure.

Consider a tobacco use cessation program.

What's Changing for 2007?

There will be no increase in health premiums and no changes in benefits.

Vendor Updates

- Kaiser Permanente will be adding a new medical center in West Cobb at the East/West Connector in early 2007.
- BlueChoice has added Catoosa, Chattahoochee, Habersham, Heard, Jasper, Murray, Putnam, Rabun, Stewart, Towns, Washington, and Whitfield counties to their service area and removed Taliaferro.
- United Healthcare has added all acute care hospitals in the State of Georgia in the PPO network.

Health Savings Account (HSA) will be Offered

The Georgia Merit System Flexible Benefits Program will offer employees who are enrolled in the High Deductible Health Plan the ability to participate in an HSA. An HSA is a tax-exempt savings account and any unused money rolls over from year-to-year.

Upcoming Eligibility Changes for 2007

- When you add a dependent and the Plan requests dependent verification documentation, you must submit the documentation requested by the Plan in order to cover the dependent. If you fail to provide dependent verification documentation on a timely basis, the dependent will not be eligible for coverage until the following Open Enrollment or a Qualifying Event occurs.
- When all covered dependents lose eligibility for coverage, the SHBP will automatically decrease the coverage tier to Employee Only under the member's current health benefit option. Loss of all covered dependents may be through divorce, death, legal separation, an only covered dependent exceeding the maximum age of eligibility, an only covered dependent no longer meeting full-time student requirements, marriage of an only covered dependent child, or a Qualified Medical Child Support Order (QMCSO) requiring a former spouse to provide health coverage for all covered natural children.
- Full-time students whose verification documentation is not submitted timely will not be eligible for coverage until the following Open Enrollment or a Qualifying Event occurs. This means that you will need to submit full-time student verification before coverage ends at age 19 and each subsequent year to keep the student's eligibility active. If you allow the student's coverage to lapse because verification documentation is submitted late, you will not be able to add the student to your coverage until the following Open Enrollment. Verification documentation must be submitted timely for a student to be covered under the Plan.
- Qualifying Event – to request the addition of an eligible dependent, submission of the request to SHBP must be made within 31 days prior to or after the Qualifying Event. (i.e. newborns, marriage, etc.)
- Documentation – you have 31 days from the date of the Qualifying Event or the date of the request for coverage, whichever is later, to provide Qualifying Event documentation and/or dependent verification documentation.
- Member contributions not remitted to the Plan by the due date may result in suspension and/or termination of coverage.
- SHBP will provide members with additional information on these eligibility changes prior to implementation.

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 healthcare 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 website 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 healthcare 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.

Wellness Tips

BlueChoice HMO

Our 360° Health program surrounds you and your family with personalized support to help you achieve and maintain your highest potential for good health. The following are descriptions of some of the programs available to you. Find out more about the programs available to you through 360° Health, by accessing www.bcbsga.com or contacting the customer service at (800) 464-1367.

- **Discounts** on wellness products, vision services, alternative practitioners and fitness clubs.
- **Healthy Living, powered by *web*MD**, a vast resource center that allows you to take part in online programs and access news and health information.
- **BlueChoice On-Call** your toll free, 24/7 connection to a registered nurse as well as to recorded information on over 400 health-related topics
- **Baby Connection** includes nurses to guide expectant mothers through their pregnancy.
- **Condition Management**, a coordinated system that provides tailored assistance for individuals who have or are at risk for a specific chronic illness or medical conditions – like asthma, diabetes, chronic obstructive pulmonary disease, coronary artery disease and heart failure. Highly personalized to address your specific health needs and lifestyle challenges.

health tip:

Keep your body moving. Exercise is important for a healthy heart. Aerobic exercise such as walking, bicycling or swimming is great for your heart.

CIGNA

CIGNA HealthCare's Healthy Rewards program can save members up to 60 percent on a range of complementary and alternative care services and products. The discounts apply whenever you use Healthy Rewards participating providers. No referral. No claim. No catch.

Some of the rewards you can enjoy include:

- Acupuncture
- Chiropractic Care
- Online Health & Beauty Products
- Fitness Club Memberships
- Hearing Care
- Laser Vision Correction
- Massage Therapy
- Natural Supplements
- Tobacco Cessation
- Weight Management
- Vision Care

If good health is its own reward, consider Healthy Rewards a well-deserved bonus.

Kaiser Permanente

Kaiser Permanente members have access to a wide variety of programs, classes, discounts, online tools, and other resources to help them stay healthy and take an active role in their own health – mind, body, and spirit.* Some of these include:

- Health coaches – at no cost – 24-hours a day, 7 days a week through Healthy Solutions.
- Discounts on health clubs, Weight Watchers, 10,000 Steps Walking Program, complementary health products, and more.
- Discounts on vision care, LASIK, chiropractic care, acupuncture, acupressure, and massage therapy.
- Free or low-cost health classes including yoga, tai chi, stress reduction, nutrition, and many others.
- Free online Total Health Assessment program that gives an in-depth health evaluation and a completely personalized action plan.
- Customized online programs to help lose weight, eat healthy, reduce stress, or quit smoking.
- Online health and drug encyclopedias, featured health topics, and other self-help resources.
- Secure 24-hour access to parts of their health record online at kp.org, including the ability to e-mail a Kaiser doctor's office, view certain lab results, review past office visit information, monitor their ongoing health conditions, and more.**

- Online message boards to discuss health topics and get support.
- Free *HealthWise Handbook* self-help guide for many common health problems.

To learn more, visit members.kp.org or call (404) 261-2590.

* Available to Kaiser Permanente members and their families. Discounts and services are provided on a fee-for-service basis, do not replace and cannot be combined with any existing benefit, and are not covered benefits. Kaiser Permanente assumes no responsibility for the arrangement, nature, quality, or outcome of the services.

**Available to members receiving care at Kaiser Permanente Medical Centers.

United Healthcare

With United Healthcare, you will enjoy the benefits of the United Healthwellness package of wellness programs, services and valuable health and well-being discounts. These programs and services are designed to complement your medical benefits plan by giving you more options to improve your and your family's total health and well-being, all at no additional cost to you! United Healthwellness provides you with a multitude of options to improve your health including:

- **The Health Assessment Survey**, this online health survey helps individuals assess their overall current state of health. After completion of the health assessment, individuals receive an immediate personalized report with their results and health improvement suggestions.
- **Online Health Improvement Programs**, this health improvement tool includes 10 six-week interactive online programs to help individuals make lifestyle changes and achieve health objectives in key targeted areas, including fitness, weight loss, nutrition, stress, smoking cessation, and more.
- **The Total Well-Being Program**, this online program helps individuals achieve a healthy and balanced lifestyle, addressing the five areas of total well-being: Physical, Intellectual, Social, Spiritual and Emotional. This is accomplished with online, personalized wellness tools, educational materials, and discounted wellness products including fitness club and weight loss center discounts.
- **The Health Value Program**, this discount program provides 10-50 percent savings on many healthcare services not covered under an individual's medical, dental or vision plan.
- **Healthy Pregnancy Program**, this program is designed to provide personal support through all stages of pregnancy and delivery. The program includes two assessments to identify special needs and identification of risk factors, a 24-hours toll-free line to experienced maternity nurses, and customized newsletters and educational materials.
- **Personal Health Manager**, this flexible, confidential online program designed to help individuals manage their health information, such as conditions, medical contacts, and doctor visits.

health tip:

Because much of your baby's development takes place in the first few weeks of pregnancy, it's important to see your doctor as soon as you think you may be pregnant.

Understanding Your Plan Options

To maximize your health benefits, it is important to fully understand how each of the SHBP options work. This brief overview will help you determine which option best fits your health care needs. **Keep in mind that failure to use network providers could result in a financial impact to you.**

It is ultimately your responsibility to verify that a provider is in the PPO or HMO network prior to receiving services. Providers may enter or leave the network at any time.

PPO Options

The PPO options offer you a network of more than 13,000 Georgia participating physicians and all acute care Georgia hospitals through United Healthcare PPO network.

You also have the added benefit of access to a national network of participating providers and hospitals across the United States.

In order to receive the highest level of benefit coverage and avoid filing claims and balance billing, you will need to 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.

All benefit appeals should be directed to United Healthcare.

A PPO Consumer Choice Option (CCO) is also available (see page 9 for more details).

To view the list of PPO providers and benefit video, visit www.myuhc.com/groups/gdch, or call 1-877-246-4189.

HMO Options

HMO options are available to SHBP-eligible employees who live or work in the county or surrounding counties in which an HMO is offered. You may be required to drive some distance if you select a provider practicing in another county.

HMOs provide 100% benefit coverage for preventive health care needs after paying applicable co-payments. Certain services are subject to a deductible and co-insurance amount (i.e., inpatient and outpatient hospital facility, inpatient professional charges, etc.). These deductibles and co-insurance amounts have an annual out-of pocket maximum. When you meet this maximum, the HMO pays your covered services at 100%. **Co-payment amounts are excluded from the annual out-of-pocket maximum.**

Diagnostic testing and lab services performed at independent radiology and lab offices located in the Kaiser facilities are subject to deductible and co-insurance.

In most HMOs, you are responsible for selecting a Primary Care Physician (PCP) from a list of participating providers (see note). When you use a provider other than your PCP, your PCP must provide a referral for your expenses to be covered (except in life threatening 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.

Note: United Healthcare Choice HMO does not require you to select a PCP or obtain referrals to see specialists.

All benefit appeals should be directed to your HMO Option.

An HMO Consumer Choice Option (CCO) is also available (see page 9 for more details).

PPO, HMO and High Deductible Health Plan Consumer Choice Options (CCO)

Selection of any CCO option does not provide enhanced benefits.

The CCO premiums are higher than the corresponding option. For the increased cost, you can request that a Georgia out-of network provider be reimbursed as an in-network provider. This is referred to as a nomination.

The out-of-network provider must accept the fees and conditions of the network and be approved by the network BEFORE you receive any services from that provider.

This in-network relationship between you and the provider exists only for you and the provider. Other family members who wish to receive in-network benefits from that provider must complete a provider nomination form. You may nominate as many providers as you wish.

SHBP rules do not allow you to change your coverage option if the provider you would like to nominate rejects the nomination.

Only providers located and licensed in Georgia are eligible for nomination.

For further details and to obtain the necessary paperwork, please call the selected plan option member services department.

Indemnity Option

The Indemnity Option is a traditional fee-for-service plan that generally provides the same benefit coverage level no matter which qualified medical provider you use. The Plan reimburses up to the Plan's allowed amounts for covered services. The Indemnity Option also uses contracted healthcare providers who have agreed to discounted rates without balance billing for charges over the allowed amount. As long as you see a participating provider, you may not be balance billed for covered services. However, not all providers participate in these special arrangements. In most instances, non-participating providers' billed charges are considerably higher than the Plan's allowed amounts.

The SHBP does not have the legal authority to intervene when non-participating providers balance bill you. As a result, the SHBP cannot reduce or eliminate amounts balance billed. The SHBP cannot make additional payments above the allowed amounts when you are balance billed by non-participating providers.

All benefit appeals should be directed to United Healthcare.

health tip:

Did you know that no single fruit or vegetable provides all of the nutrients needed to be healthy? The key lies in choosing a colorful variety of fruits and vegetables.

High Deductible Health Plan

The High Deductible Health Plan (HDHP) covers the same services and supplies as the SHBP's PPO Option and includes the same network of participating physicians and hospitals – here in Georgia and across the United States. The HDHP has the following differences from the other plan options:

- Your monthly insurance premiums are lower
- **You have a higher deductible that applies to everything except the first $500 in preventive care expenses. If you have family coverage, you must meet the family deductible before benefits are payable for any family member.**
- You pay coinsurance after you have satisfied the deductible rather than set dollar co-payments for network office visits and prescription drugs.
- You may qualify to start a Health Savings Account (HSA) for yourself and set aside tax-free dollars to pay for eligible healthcare expenses now or in the future. HSAs typically earn interest and may even offer investment options.

health tip:

Caring for your mind, as well as your body is good for overall health and key to your success at home, at work and at school.

Your Health Savings Account (HSA) Opportunity

An HSA is like a personal savings account for healthcare, 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 only open an HSA if you enroll in the SHBP HDHP and do not have other coverage through your spouse's employer's plan, Medicare, Medicaid, an Health Care Spending Account (HCSA) or any other non-qualified medical plan.

HSA Highlights

What you can contribute each year	Up to HDHP deductible amount: • $1,100 if you have individual coverage • $2,200 if you have family coverage as long as you continue to be enrolled in an HDHP (Note these amounts may be indexed based on federal cost of living factors.)
What happens at the end of the year	Unused money in your account carries forward and continues to earn interest.
What happens if you don't enroll in an HDHP next year or leave your employer	You can no longer contribute to your HSA, but you keep the account and can continue to use the balance for eligible healthcare expenses
When is money available	Money is available only if actually in your account

While funds in the HSA are not subject to forfeitures and can be carried over from year to year, the HSA may not be right for all employees in a HDHP. Please read the HSA information carefully so that you understand the benefits as well as the limitations.

See pages 20-21 for more detail on the HDHP and the opportunity it provides to enroll in an HSA. See the Benefits Comparison chart that starts on page 12 for more information about how the plan covers specific expenses.

TRICARE Supplement for Eligible Military Members

The TRICARE Supplement Insurance is offered to employees and dependents who are eligible for TRICARE and who have a Defense Enrollment Eligibility Reporting System (DEERS) number.

Considerations

- TRICARE will become your primary insurance.
- TRICARE Supplement will become your secondary coverage.
- Tobacco and spousal surcharges do not apply.
- *If you enroll in the TRICARE Supplement and are not eligible, you will be enrolled in the PPO Option which includes the spousal and tobacco surcharges. You will be required to pay the PPO premiums retroactive to your date of ineligibility or your coverage will be terminated effective January 1, 2007.*
- **You do not have to enroll in Medicare Part D if you are enrolled in the TRICARE Supplement.**

Dependents

- To cover a child past age 19, your child must be a full-time student.
- You may cover your full-time student from age 19-23 under the TRICARE Supplement
- To cover your full-time student from age 23-26, you must select another SHBP option during the Open Enrollment period prior to your child reaching age 23.
- Your child must meet State Health Benefit Plan and TRICARE eligibility requirements. Contact TRICARE for their eligibility requirements.

What Happens at Age 65

- When you and/or your spouse are ineligible for Medicare, the TRICARE Supplement continues with submission of disallowance by Social Security.
- When you and/or your spouse are entitled to Medicare Part A and enrolled in Medicare Part B, your coverage will continue through the TRICARE Supplement.
- When you and/or your spouse are eligible for Medicare, Medicare will be your primary insurance, TRICARE for Life – secondary, and the TRICARE Supplement – Tertiary.
- When you or your spouse are eligible for Medicare, if you wish to cover your spouse through SHBP, you need to select another SHBP option during the Open Enrollment Period prior to you or your spouse reaching age 65.
- Attainment of age 65 and eligibility for Medicare is a qualifying event and will allow you to change to another Plan option.
- When you and/or your spouse reach age 65 and reside overseas, your coverage will continue through the TRICARE Supplement if you are entitled to Medicare Part A and are enrolled in Medicare Part B.

Benefits Comparison: PPO, Indemnity, HDHP and HMO Options

Schedule of Benefits for You and Your Dependents for January 1, 2007–December 31, 2007

Dollar amounts, visit limitations, deductibles and out-of-pocket limits are based on a January 1–December 31, 2007 Plan Year.

NOTE: Coverage is defined as allowed eligible expenses.

	PPO OPTION		INDEMNITY
	In-Network	Out-of-Network	
Covered Services	*The Plan Pays:*		*The Plan Pays:*
Maximum Lifetime Benefit (combined for all SHBP Options)	$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 PPO Option, Indemnity and HDHP) • Temporomandibular joint dysfunction (TMJ) • Substance abuse	$1,100 3 episodes		$1,100 3 episodes
Deductibles/Co-Payments: • Deductible—individual • Deductible—family maximum	$500 $1,500	$600 $1,800	$500 $1,500
• Hospital deductible per admission	$250		$400
Annual Out-of-Pocket Limits: • Individual • Family	$1,100 $2,200	$2,200 $4,400	$2,200 $4,400
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% of coverage; subject to deductible	90% of coverage; subject to deductible
Primary Care Physician or Specialist Office or Clinic Visits for the Following: • Wellness care/preventive healthcare • 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 $500 per person per Plan Year.	Not covered. Charges do not apply to deductible or annual out-of-pocket limits.	90% per office visit after deductible. 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.
Maternity Care (prenatal, delivery and postpartum)	90% of coverage; not subject to deductible after initial $30 co-payment	60% of coverage; subject to deductible	90% of coverage; subject to deductible

*Don't forget the **TRICARE Supplement Option** (see page 11 for more information)*

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, CIGNA, Kaiser Permanente, UnitedHealthcare	
The Plan Pays:		*The Plan Pays:*	*HMO Plan Differences*
$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	
* You must meet the family deductible before benefits are payable for any family member.			
Not applicable		Not applicable	
$1,700 $2,900	$3,800 $7,000	$1,000 $2,000	
90% of coverage; subject to deductible	60% of 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 up to a maximum of $500 per person per Plan Year. 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.	
90% of coverage; subject to deductible	60% of coverage; subject to deductible	100% after initial $25 co-payment	

Chart continued pg. 14

	PPO OPTION		INDEMNITY
	In-Network	Out-of-Network	
Physicians' Services	*The Plan Pays:*		*The Plan Pays:*
Physician Services Furnished in a Hospital Surgery in general, including charges by surgeon, anesthesiologist, pathologist and radiologist	90% of coverage; subject to deductible	60% of coverage; subject to deductible	90% of coverage; subject to deductible
Physician Services for Emergency Care Non-emergency use of the emergency room not covered.	90% of coverage; subject to deductible	90% of coverage; subject to in-network deductible	90% of coverage; subject to deductible
Outpatient Surgery— • When billed as office visit	90% of coverage; subject to deductible	60% of coverage; subject to deductible	90% of coverage; subject to deductible
• When billed as outpatient surgery at a facility	90% of coverage; subject to deductible	60% of coverage; subject to deductible	90% of 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% of coverage; subject to deductible	90% of coverage; subject to deductible
Hospital Services			
Inpatient Services • Inpatient care, delivery and inpatient short-term acute rehabilitation services	90% of coverage; subject to a $250 per admission deductible	60% of coverage; subject to a $250 per admission deductible	90% of coverage; subject to a $400 per admission deductible
• Well-newborn care	100% of coverage; not subject to deductible	60% of coverage; subject to a $250 per admission deductible	90% of coverage; not subject to deductible
Outpatient Surgery— Hospital/Facility	90% of coverage; subject to deductible	60% of coverage; subject to deductible	90% of coverage; subject to deductible
Emergency Care— Hospital/Facility Treatment of an emergency medical condition or injury Non-emergency use of the emergency room not covered.	90% of coverage after a $100 per visit co-payment; co-payment waived if admitted; subject to deductible	90% of coverage after a $100 per visit co-payment; co-payment waived if admitted; subject to deductible	90% of coverage after a $100 per visit co-payment; co-payment waived if admitted; 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% of coverage; subject to deductible	60% of coverage; subject to deductible	90% of coverage; subject to deductible

*Don't forget the **TRICARE Supplement Option** (see page 11 for more information)*

HIGH DEDUCTIBLE OPTION		HMO OPTIONS	
In-Network	Out-of-Network	BlueChoice, CIGNA, Kaiser Permanente, UnitedHealthcare	
The Plan Pays:		*The Plan Pays:*	*HMO Plan Differences*
90% of coverage; subject to deductible	60% of coverage; subject to deductible	90% of coverage; subject to deductible	
90% of coverage; subject to deductible	90% of coverage; subject to deductible	100% after $100 co-payment	Non-emergency use of the emergency room not covered. Applies to all plan options.
90% of coverage; subject to deductible	60% of coverage; subject to deductible	100% after $25 co-payment if billed as office visit	Kaiser Permanente – 90% of coverage; subject to deductible
90% of coverage; subject to deductible	60% of coverage; subject to deductible	90% of coverage; subject to deductible	
90% of coverage; subject to deductible	60% of 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. United Healthcare – no co-pay if office visit not billed.
90% of coverage; subject to deductible	60% of coverage; subject to deductible	90% of coverage; subject to deductible	
90% of coverage; subject to deductible	60% of coverage; subject to deductible	100% of coverage not subject to deductible	
90% of coverage; subject to deductible	90% of coverage; subject to deductible	90% of coverage; subject to deductible	
90% of coverage; subject to deductible	90% of coverage; subject to deductible	100% after a $100 per visit co-payment; co-payment waived if admitted	Non-emergency use of the emergency room not covered. Applies to all plan options.
90% of coverage; subject to deductible	60% of coverage; subject to deductible	90% of coverage; subject to deductible	Kaiser Permanente – lab and x-rays may be subject to deductible. United Healthcare – independent lab/x-ray are payable at 100%.

Chart continued pg. 16

	PPO OPTION		INDEMNITY
	In-Network	Out-of-Network	
Behavioral Health	*The Plan Pays:*		*The Plan Pays:*
Mental Health and Substance Abuse Inpatient Facility **NOTE:** All services require prior authorization.	90% of coverage; subject to deductible limited to 45 days combined per Plan Year	60% of coverage; subject to deductible limited to 45 days combined per Plan Year	90% of coverage; subject to deductible limited to 45 days combined per Plan Year
Partial Day Hospitalization and Intensive Outpatient **NOTE: Notification Required.**	90% of coverage; subject to deductible limited to 60 days combined per Plan Year	No benefit	90% of coverage; subject to deductible limited to 60 days combined per Plan Year
Professional Charges Inpatient	90% of coverage; subject to deductible; limited to 1 visit per authorized day combined per Plan Year	60% of coverage; subject to deductible; limited to 1 visit per authorized day combined per Plan Year	90% of coverage; subject to deductible; limited to 1 visit per authorized day combined per Plan Year
Mental Health and Substance Abuse Outpatient Visits **NOTE: Notification Required.**	90% of coverage; subject to deductible, limited to 50 visits per Plan Year (the 50 visit limit includes any out-of-network visits)	60% of coverage; subject to deductible; limited to 25 visits per Plan Year (not to exceed a total of 50 visits combined)	90% of coverage; subject to deductible; limited to 50 visits per Plan Year
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% of coverage; subject to deductible	60% of coverage; subject to deductible	90% of coverage; subject to deductible
Temporomandibular Joint Syndrome (TMJ) **NOTE:** Coverage for diagnostic testing and non-surgical treatment up to $1,100 per person lifetime maximum benefit. This does not apply to the HMO.	90% of coverage; subject to deductible	60% of coverage; subject to deductible	90% of coverage; subject to deductible
Vision			
	90% of coverage; not subject to deductible; limited to one eye exam every 24 months	Eye exam not covered	90% of coverage; not subject to deductible; limited to one eye exam every 24 months
Other Coverage			
Ambulance Services for Emergency Care **NOTE:** "Land or air ambulance" to nearest facility to treat the condition.	90% of coverage; subject to deductible	90% of coverage; subject to deductible	90% of coverage; subject to deductible

*Don't forget the **TRICARE Supplement Option** (see page 11 for more information)*

HIGH DEDUCTIBLE OPTION		HMO OPTIONS	
In-Network	Out-of-Network	BlueChoice, CIGNA, Kaiser Permanente, UnitedHealthcare	
The Plan Pays:		*The Plan Pays:*	*HMO Plan Differences*
90% of coverage; subject to deductible limited to 30 days combined per Plan Year	60% of coverage; subject to deductible limited to 30 days combined per Plan Year	90% of coverage; not subject to deductible and limited to 30 days combined per Plan Year	Kaiser Permanente – 90% of coverage; subject to deductible and unlimited days for mental health; 30-day limit for substance abuse
90% of coverage; subject to deductible limited to 60 days combined per Plan Year	60% of coverage; subject to deductible limited to 30 days combined per Plan Year	Each HMO may or may not offer this benefit; contact the HMO for more information	
90% of coverage; subject to deductible limited to 1 visit per authorized day combined per Plan Year	60% of coverage; subject to deductible limited to 1 visit per authorized day combined per Plan Year	90% of coverage; not subject to deductible	Kaiser Permanente – 90% of coverage; subject to deductible
90% of coverage; subject to deductible limited to 50 visits combined per Plan Year	60% of coverage; subject to deductible limited to 25 visits combined per Plan Year	100% after $25 per visit co-payment; limited to 25 visits combined per Plan Year	
90% of coverage; subject to deductible	60% of coverage; subject to deductible	100% after applicable co-payment, if inpatient/ outpatient facility; subject to deductible	Kaiser Permanente – 50% coverage on first $1,000, if inpatient/ outpatient facility; subject to deductible
90% of coverage; subject to deductible	60% of 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% of coverage; not subject to deductible; limited to one eye exam every 24 months	Eye exam not covered	Contact HMO directly for more information	
90% of coverage; subject to deductible	90% of coverage; subject to deductible	100%	Kaiser Permanente – 100% after a $50 per trip co-payment when medically necessary.

Chart continued pg. 18

	PPO OPTION		INDEMNITY
	In-Network	Out-of-Network	
Other Coverage	*The Plan Pays:*		*The Plan Pays:*
Urgent Care Services	90% of coverage after a $45 per visit co-payment; subject to deductible	60% of coverage; subject to deductible	90% of coverage; subject to deductible
Home Healthcare Services **NOTE:** Prior approval required	90% of coverage; subject to deductible	60% of coverage; subject to deductible	90% of coverage; subject to deductible
Skilled Nursing Facility Services **NOTE:** Prior approval required	90% of coverage; up to 45 days per Plan Year; subject to a $250 per admission deductible	Not covered	90% of coverage; up to 45 days per Plan Year; subject to a $400 per admission deductible @ contracted facility
Hospice Care **NOTE:** Prior approval required	100% of coverage; subject to deductible	60% of coverage; subject to deductible	100% of coverage; subject to deductible
Durable Medical Equipment (DME)—Rental or Purchase	90% of coverage; subject to deductible	60% of coverage; subject to deductible	90% of coverage; subject to deductible
Outpatient Acute Short-Term Rehabilitation Services	90% of coverage; subject to deductible and $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% of 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% of coverage; subject to deductible and $20 per visit co-payment up to 40 visits per Plan Year
Chiropractic Care **NOTE:** Coverage for up to a maximum of 20 visits per Plan Year	90% of coverage; after a $30 per visit co-payment; not subject to deductible	60% of coverage; subject to deductible	90% of coverage; subject to deductible
Transplant Services **NOTE:** Prior approval required	90% of coverage; subject to deductible at contracted transplant facility	Not covered	90% of coverage; subject to deductible at contracted transplant facility
Pharmacy			
Tier 1 Co-payment	$10	$10*	$10
Tier 2 Co-payment	$30	$30*	$30
Tier 3 Co-payment	$100	$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.

*Don't forget the **TRICARE Supplement Option** (see page 11 for more information)*

HIGH DEDUCTIBLE OPTION		HMO OPTIONS	
In-Network	Out-of-Network	BlueChoice, CIGNA, Kaiser Permanente, UnitedHealthcare	
The Plan Pays:		*The Plan Pays:*	*HMO Plan Differences*
90% of coverage; subject to deductible	60% of coverage; subject to deductible	100% after $25 co-payment	BlueChoice – referral required. Kaiser Permanente – 100% after $30 co-payment
90% of coverage; subject to deductible	60% of coverage; subject to deductible	100% of coverage; up to 120 visits per Plan Year	
90% of coverage up to 45 days per Plan Year; subject to deductible	Not covered	90% of coverage; up to 45 days per Plan Year; subject to deductible	United Healthcare – 90% of coverage, up to 120 days per Plan Year; subject to deductible
90% of coverage; subject to deductible	60% of coverage; subject to deductible	100% of coverage; subject to deductible	CIGNA – 90% of coverage; subject to deductible; outpatient 100% not subject to deductible
90% of coverage; subject to deductible	60% of coverage; subject to deductible	100% of coverage when medically necessary	United Healthcare – notification required for items over $1,000.
90% of coverage up to 40 visits per Plan Year; subject to deductible	60% of coverage up to 40 visits per Plan Year; subject to deductible	100% of coverage after $25 per visit co-payment; up to 40 visits per Plan Year	
90% of coverage; subject to deductible	60% of coverage; subject to deductible	100% of coverage after $25 co-payment per visit	
90% of coverage; subject to deductible at contracted transplant facility	Not covered	90% of coverage; subject to deductible	
80% of coverage; subject to deductible $10 min./$100 max.	Not covered	$10	Kaiser Permanente – Kaiser facility: $10 Network Pharmacies: $16
80% of coverage; subject to deductible $10 min./$100 max.	Not covered	$25	Kaiser Permanente – Kaiser facility: $25 Network Pharmacies: $31
80% of coverage; subject to deductible $10 min./$100 max.	Not covered	$50	Kaiser Permanente – N/A

Important Plan Considerations

Important PPO and Indemnity Considerations

See the Summary Plan Description for coverage details, including limitations and exclusions.

You are required to obtain the necessary prior notification or prior approval for all inpatient admissions and certain covered services under the Plan. You should contact member services regarding notification requirements and verification of covered services.

- A change to the provider network is not a qualifying event and the member may not change Plan options.
- Charges from non-participating 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.
- Services covered under the PPO from in-network providers will apply to the in-network deductible and out-of-pocket limit.
- Services covered under the PPO from out-of-network providers apply to the out-of-network deductible and out-of-pocket limit.
- Co-payments do not apply toward deductibles or out-of-pocket limits unless otherwise noted.

If you should go to the pharmacy and are told that your prescription cannot be filled because it requires prior authorization, please have your doctor call the pharmacy benefit manager with your clinical information.

health tip:

Are there specific factors that contribute to your health? Are they hereditary? Are they controllable? You can find out by taking a Health Risk Assessment (information will be kept confidential) on your Health Option's website. Through the assessment, you will learn what to do to gain better control of your health and well-being.

High Deductible Health Plan/HSA Considerations

The HDHP covers the same services and supplies as the SHBP's PPO Option, and includes the same network of participating physicians and hospitals – here in Georgia and across the United States. The HDHP also reflects the importance of preventive care, with a $500 annual benefit with no deductible.

You are required to obtain the necessary prior notification or prior approval for all inpatient admissions and certain covered services under the Plan. You should contact member services regarding notification requirements and verification of covered services.

Deductibles:

- The deductible applies to everything except the first $500 in preventive care expenses. If you have family coverage, you must meet the family deductible before benefits are payable for any family member.
- With the HDHP, you pay coinsurance after the deductible for in-network office visits and prescription drugs.

See the Summary Plan Description on the web, www.dch.georgia.gov/shbp_plans for coverage details, including limitations and exclusions.

- In return for lower monthly health premiums, you have a higher deductible and if you have family coverage, you must meet the family deductible before benefits are payable for any family member.
- You pay coinsurance after the deductible for in-network office visits and prescription drugs.
- If you are 55 or older, you may contribute additional dollars – up to $700 a year as "catch-up" contributions.

- Contributions can be made through payroll deductions or through deposits you or someone else make directly to the HSA.
- HSA dollars can be used to pay for healthcare expenses (medical, dental, vision, over-the-counter medications) the IRS considers tax-deductible that are not covered by any healthcare plan (see IRS Publication 502 at www.irs.gov).
- Claims payments vary based on HSA administrator, but generally you can pay expenses directly from your account (using a debit card or convenience checks), so there's no claim paperwork to submit
- At year-end, unused money in your account carries forward and continues to earn interest.
- If your leave your employer or don't re-enroll in an HDHP Option, you can no longer contribute to your HSA, but you keep the account and can continue to use the balance for eligible healthcare expenses.
- HSA administrators typically charge a monthly maintenance fee and sometimes, additional transaction fees.
- HSAs typically earn interest and there are investment options once a pre-defined threshold is reached.
- HSA accounts can not be combined with a general purpose spending account.
- HSA accounts can be combined with a limited purpose spending account, if offered.
- HSA dollars are not available unless the money is in your account.
- If you are NOT participating in the State of Georgia Flexible Benefits Program, contact your Benefits Coordinator to see if you have the ability to participate in an HSA.
- If covered by Medicare, you are not eligible to contribute to an HSA.

Important HMO Considerations

- Distance to the nearest physician's office or hospital (If you enroll in an HMO offered in another county, you may have to drive a distance to see your doctor or to go to a participating hospital).
- A change in the provider network is not a qualifying event and the member may not change Plan options.
- To be covered, you must see an in-network provider unless there is a life threatening emergency.
- Verify provider participation before selecting an HMO Option.
- Some services may require prior authorization by the HMO to be 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. If you do not select a PCP, the HMO will assign you a PCP located near your residence. **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 denial of your claim. **Note: UnitedHealthcare does not require a referral for coverage of specialist services.**

Surcharges

Tobacco

SHBP charges a tobacco surcharge if SHBP members or one of their dependents use tobacco products. You may have the tobacco surcharge removed by:

- Quit using tobacco products and attend a tobacco cessation program sponsored by Kaiser, the American Cancer Society, the American Lung Association, or other approved programs listed on the DCH website. Check the DCH website for any updates at www.dch.georgia.gov/shbp_plans.
- You will receive an attendance certification form. You and the representative should both sign this form.
- Complete and submit the appropriate Tobacco Affidavit Form and attendance certification form to your payroll location Benefit Coordinator to complete the required deduction information. The Affidavit Form is available at www.dch.georgia.gov/shbp_plans.

Spousal

SHBP charges a spousal surcharge for SHBP members who cover their spouses. You may have the spousal surcharge removed:

- If your spouse becomes covered by his/her employer's health benefit plan, and
- If you make the request and provide proof within 31 days of the effective date of the other coverage.

No refund in premiums will be made for previous health deductions that included the surcharge amounts.

Notes Apply to All Options:

Pharmacy:

- Pharmacy Benefit Drug Co-payments are based on a three (3) Tier system. Tier One (1) represents the lowest co-payment, Tier Two (2) the middle co-payment, and Tier Three (3) the highest co-payment. The HDHP drug benefit is subject to co-insurance.
- The Tier your drug is in is subject to change. Prior to purchasing your medication(s), PPO and Indemnity members may view the drug lists at www.dch.georgia.gov/shbp_plans or contact the pharmacy benefit manager at 1-877-650-9342 or TDD 1-800-842-5754.
- HMO members may contact the HMO option in which they are enrolled for information about covered drugs.
- Many drugs listed as Tier 3 have a Tier 1 or a Tier 2 alternative. Tier 1 & 2 drug alternatives are therapeutically equivalent while being more cost effective.
- If the drug cost is less than the co-payment, you do not have to pay the co-payment but the actual cost of the drug.
- Co-payments for drugs covered under the SHBP will not be changed or overridden on an individual basis.
- The SHBP defines maintenance drugs as medications for specified chronic conditions. PPO, PPO CCO, Indemnity and Kaiser members may obtain up to a 90-day supply of maintenance prescription(s) at one time for three co-payments. BlueChoice, CIGNA, and UnitedHealthcare Choice HMO members may receive a 90-day supply of maintenance prescriptions for two co-payments. HDHP members may obtain up to a 90-day supply by paying the 60-day co-insurance amount. Your co-payments are based on supplies of up to 30-days as this is the industry standard. However, some drugs are limited to a standard other than the 30-day supply for one co-payment. HDHP members may receive a 31-day supply by paying 20% after satisfying the $1,100 deductible with a $10 minimum/$100 maximum per prescription.

Other:

- Annual dollar and visit limitations, deductibles and out-of-pocket spending limits are based on January 1, 2007 to December 31, 2007.
- Lifetime benefit maximums are combined totals among the PPO Options, Indemnity, HDHP Option and HMO Options.
- Contact each plan directly for more details regarding covered services, exclusions and limitations.

health tip:

Did you know that regular visits to the dentist may do more than brighten your smile? Research has linked periodontal (gum) disease to complications such as stroke, diabetes, pre-term birth and other health issues.

State Health Benefit Plan Medicare Policy

The following information and "Important Notices about your Prescription Drug Coverage and Medicare" are provided to assist you with Retirement Planning.

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 27).

1 SHBP calculates premiums and claims payment 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 Part A, B and/or D. Premiums will be reduced for each part of Medicare for which the retiree enrolls.

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.

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 Open Enrollment period prior to your retirement.

Once retired, during the annual Retiree Option Change Period, you are allowed to change your Plan Option only. You may add dependents only if you experience a qualifying event, request the change within 31 days and provide the documentation required by SHBP.

health tip:

If you have diabetes, it is important to take care of yourself every day by taking your medications as prescribed and following a dietary and exercise plan outlined by your doctor.

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 indicate 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.

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 at 404-233-3700.

Georgia Department of
Community Health
Two Peachtree Street
Atlanta, GA 30303
(404) 656-6322 • (800) 610-1863

October 1, 2006

Important Notice from the SHBP

About Your Prescription Drug Coverage with PPO, Indemnity, CIGNA, United Healthcare Choice HMO, Kaiser Permanente, BlueChoice, TRICARE Supplement Plan and Medicare

For Plan Year: January 1 – December 31, 2007

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 prescription drug coverage available for people with Medicare. It also explains the options you have under Medicare prescription drug coverage and can help you decide whether or not you want to enroll. At the end of this notice is information about where you can get help to make decisions about your prescription drug coverage.

1 Medicare prescription drug coverage became available in 2006 to everyone with Medicare through Medicare prescription drug plans and Medicare Advantage Plans that offer prescription drug coverage. All Medicare prescription 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 State Health Benefit Plan (SHBP) has determined that the prescription drug coverage offered by the SHBP is, on average for all plan participants, expected to pay out as much as the standard Medicare prescription drug coverage will pay and is considered Creditable Coverage.

Because your existing coverage is on average at least as good as the standard Medicare prescription drug coverage, you can keep your SHBP coverage and not pay extra for Part D (if you later decide) to enroll in Medicare prescription drug coverage.

Individuals can enroll in a Medicare prescription drug plan when they first become eligible for Medicare and each year from November 15th through December 31st. Beneficiaries losing their SHBP coverage may be eligible for a Special Enrollment Period to sign up for a Medicare prescription drug plan.

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.

Your current coverage pays for other health expenses in addition to prescription drugs, and you will still be eligible to receive all of your current health benefits if you choose to enroll in a Medicare prescription drug plan. If you keep your SHBP coverage and elect Part D, SHBP will coordinate with Part D coverage. **If you do decide to enroll in a Medicare prescription drug plan and drop your coverage with the State Health Benefit Plan, be aware that you and your dependents will not be able to get this coverage back if you are a retiree.**

Please contact us for more information about what happens to your coverage if you enroll in a Medicare prescription drug plan.

You should also know that if you drop or lose your coverage with SHBP and don't enroll in Medicare prescription drug coverage after your current coverage ends, you may pay more (a penalty) to enroll in Medicare prescription drug coverage later.

If you go 63 days or longer without prescription drug coverage that's at least as good as Medicare's prescription drug coverage, your Medicare Part D monthly premium will go up at least 1% per month for every month that you did not have that coverage. For example, if you go nineteen months without coverage, your premium will always be at least 19% higher than what many other people pay. You'll have to pay this higher premium as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following November to enroll.

For more information about this notice or your current prescription drug coverage…

Contact our office for further information; call SHBP Eligibility Unit at (404) 656-6322 or (800) 610-1863. NOTE: You will receive this notice annually and at other times in the future such as before the next period you can enroll in Medicare prescription drug coverage, and if this coverage through SHBP 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'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare prescription drug plans. For more information about Medicare prescription drug plans:

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

For people with limited income and resources, extra help paying for Medicare prescription drug coverage is available. Information about this extra help is available from the Social Security Administration (SSA) online at www.socialsecurity.gov, or you call them at 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this notice. If you enroll in one of the new plans approved by Medicare which offer prescription drug coverage, you may be required to provide a copy of this notice when you join to show that you are not required to pay a higher premium amount.

Date: October 1, 2006
Name of Entity/Sender: State Health Benefit Plan
Contact: Eligibility Unit
Address: Two Peachtree Street,
Atlanta, GA 30303
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, 2006

Important Notice from the SHBP

About Your High Deductible Health Plan Prescription Drug Coverage and Medicare

For Plan Year: January 1 – December 31, 2007

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 prescription drug coverage available for people with Medicare. It also explains the options you have under Medicare prescription drug coverage, and can help you decide whether or not you want to enroll. At the end of this notice is information about where you can get help to make decisions about your prescription drug coverage.

1 Medicare prescription drug coverage became available to everyone with Medicare through Medicare prescription drug plans and Medicare Advantage Plans that offer prescription drug coverage in 2006. All Medicare prescription 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 under the High Deductible Health Plan (HDHP) is, on average for all plan participants, NOT expected to pay out as much as the standard Medicare prescription drug coverage will pay and is considered Non-Creditable Coverage. This is important, because for most people enrolled in the HDHP under the SHBP enrolling in Medicare prescription drug coverage means you will get more assistance with drug costs than if you had prescription drug coverage exclusively through the HDHP under 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 enroll. Read this notice carefully – it explains your options.

Consider enrolling in Medicare prescription drug coverage.

Because the coverage you have with the HDHP is on average for all plan participants, NOT expected to pay out as much as the standard Medicare prescription drug coverage will pay, consider enrolling in a Medicare prescription drug plan. Individual's can enroll in a Medicare prescription drug plan when they first become eligible for Medicare and each year from November 15th through December 31st. Beneficiaries losing SHBP coverage may be eligible for a Special Enrollment Period to sign up for a Medicare prescription drug plan.

This may mean that you will have to wait to enroll in Medicare prescription drug coverage and that you may pay a higher premium (a penalty) if you join Medicare Part D later, you will pay that higher premium as long as you have Medicare prescription drug coverage.

If you go 63 days or longer without prescription drug coverage that is at least as good as Medicare's prescription drug coverage, your Medicare Part D premium will go up at least 1% per month for every month after May 15, 2006, that you did not have that coverage. You will have to pay this higher premium as long as you have Medicare prescription drug coverage. For example, if you go nineteen months without coverage, your premium will always be at least 19% higher than what many other people pay.

You Need to Make a Decision

When you make your decision, you should also 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.

Your current coverage pays for other health expenses, in addition to prescription drugs and you will still be eligible to receive all of your current health benefits if you choose to enroll in a Medicare prescription drug plan. If you keep your SHBP coverage and elect Part D, SHBP will coordinate with Part D coverage. If you are a retiree and decide to enroll in a Medicare prescription drug plan and drop your coverage with the SHBP, be aware that you and your dependents will not be able to get this coverage back.

For more information about this notice or your current prescription drug coverage…

Contact our office for further information or call the SHBP Eligibility Unit at (404) 656-6322 or (800) 610-1863. NOTE: You will receive this notice annually and at other times in the future, such as before the next period you can enroll in Medicare prescription drug coverage, and if this coverage through the High Deductible Health Plan 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 from Medicare. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare-approved prescription drug plans. For more information about Medicare prescription drug plans:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see 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.

For people with limited income and resources, extra help paying for Medicare prescription drug coverage is available. Information about this extra help is available from the Social Security Administration (SSA) online at www.socialsecurity.gov, or you call them at 1-800-772-1213 (TTY 1-800-325-0778).

Date: October 1, 2006
Name of Entity/Sender: State Health Benefit Plan
Contact: Eligibility Unit
Address: Two Peachtree Street,
Atlanta, GA 30303
Phone Number: (404) 656-6322 or (800) 610-1863

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, PPO CCO and Indemnity Options contain a pre-existing condition (PEC) limitation. Specifically, the Health Plan will not pay charges that are over $1,000 for the treatment of any pre-existing condition during the first 12 months of a patient's coverage, unless the patient gives satisfactory documentation that he or she has been free of treatment or medication for that condition for at least six consecutive calendar months. However, a 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 or she has the right to obtain a certificate of creditable coverage from his or her former employer(s) to offset the pre-existing condition limitation period under the SHBP. The SHBP will evaluate the certificate of creditable coverage or other documentation to determine whether any of the pre-existing condition limitation period will be reduced or eliminated. After completing the evaluation, the SHBP will notify you as to how the pre-existing condition limitation period will be reduced or eliminated.

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

Department of Community Health Privacy Notice

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

The Plan's Privacy Commitment to You

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

Understanding the Type of Information that the Plan Has

SHBP records indicate that you have previously provided information to us. This information included your name, address, birth date, phone number, Social Security Number, gender and Medicare information, if applicable. When your healthcare providers send claims to the Plan's claims administrator for payment, the claims include your diagnoses and the medical treatments you received. For some medical treatments, your healthcare providers send additional medical information to the Plan such as doctor's statements, x-rays or lab test results.

Your Health Information Rights

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

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

Privacy Law's Requirements

DCH is required by law to:

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

In the future, DCH may change its privacy practices. If its privacy practices change significantly, DCH will provide a new notice to you. DCH will post the new notice on its Web site at www.dch.state.ga.us (click on "Privacy"). This notice is effective April 14, 2003.

How DCH Uses and Discloses Healthcare Information

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

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

For Payment

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

For Medical Treatment

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

To Operate Various Plan Programs

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

To Other Government Agencies Providing Benefits or Services

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

To Keep You Informed

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

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

For Research

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

As Required by Law

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

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

For More Information or to Report a Problem

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

If you believe your privacy rights have been violated:

- You can file a complaint with the Plan by calling the SHBP at 404-656-6322 (Atlanta calling area) or 800-610-1863 (outside of Atlanta calling area), or by writing to: SHBP–HPU, P.O. Box 38342, Atlanta, GA 30334.
- You can file a complaint with the Health and Human Services Office for Civil Rights by writing to: U.S. Department of Health and Human Services Office for Civil Rights, Region IV, Atlanta Federal Center, 61 Forsyth Street SW, Suite 3B70, Atlanta, GA 30303-8909. Phone 404-562-7886; Fax 404-562-7881; TDD 404-562-7884.
- You also may contact the HHS Office for Civil Rights by calling 866-OCR-PRIV (866-627-7748) or e-mailing the OCR at OCRComplaint@hhs.gov.

There will be no retaliation for filing a complaint.

Women's Health and Cancer Rights Act

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

Following cancer surgery, the SHBP covers:

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

Note: Reconstructive surgery requires prior approval, and all inpatient admissions require prior notification.

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

Penalties for Misrepresentation

If an SHBP participant misrepresents eligibility information when applying for coverage, during change of coverage or when filing for benefits, the SHBP may take adverse action against the participant, including but not limited to terminating coverage (for the participant and his or her dependent[s]) or imposing liability to the SHBP for fraud or indemnification (requiring payment for benefits to which the participant or his or her beneficiaries were not entitled). Penalties may include a lawsuit, which may result in payment of charges to the Plan or criminal prosecution in a court of law.

In order to avoid enforcement of the penalties, the participant must notify the SHBP immediately if a dependent is no longer eligible for coverage or if the participant has questions or reservations about the eligibility of a dependent. This policy may be enforced to the fullest extent of the law.

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.

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