



GEORGIA DEPARTMENT OF
COMMUNITY HEALTH

State Health Benefit Plan

July 1, 2001 – June 30, 2002



[for RETIREES]

Health Plan Guide



Important Phone Numbers and Web Sites

For more benefit or provider information, please contact the service providers directly.

HMO Options

- Aetna US Healthcare:
—(800) 444-0759
- Aetna US Healthcare Consumer Choice:
—(800) 443-6917
- Aetna US Healthcare Web site:
—www.aetnaushc.com
- BlueChoice:
—(800) 464-1367
- BlueChoice Consumer Choice:
—(800) 464-1367
- BlueChoice Web site:
—www.bcbsga.com
- Kaiser Permanente:
—(404) 261-2590
- Kaiser Permanente Consumer Choice:
—(404) 261-2590
- Kaiser Medicare+Choice:
—(800) 956-1358
- Kaiser Permanente Web site:
—www.kp.org/ga

Standard PPO, PPO Choice, High Options

- Pharmacy Benefit Program: Contact Express Scripts at
—(877)-650-9342
- Retiree Help Line:
(April 9, 2001 – May 15, 2001)
—(800) 230-2291
- Member Services
(Through June 30, 2001)
(outside Atlanta)
—(800) 483-6983
(inside Atlanta)
—(404) 233-4479
- Retiree Member Services Unit
(Starting July 1, 2001)
—(800) 586-9288
- TDD line for hearing impaired:
—(404) 842-8073

Standard PPO, PPO Choice Options

- Online Provider Information:
—Georgia PPO
—National PPO
www.healthypeorgia.com

Note: If you don't have Internet access, you may call Member Services for each Plan option to see if any doctors were added or deleted since directories were printed.

PPO Choice Option

- New Patient Availability, Nominations of PPO Provider, and Provider Information:
(outside Atlanta)
—(800) 483-6983
(inside Atlanta)
—(404) 233-4479
- Nomination of BHS Provider Information:
—(800) 631-9943
BHSTDD line for the hearing impaired:
—(678) 319-3860
- Nomination of Transplant Provider Information:
(outside Atlanta)
—(800) 762-4535
(inside Atlanta)
—(770) 438-9770

Information on Medicare or Insurance Premiums

To find out more about your Medicare premiums, Social Security benefits, applying for Medicare, or to locate the Social Security office nearest you, contact:

- Social Security Administration
—Toll free: (800) 772-1213
—Web site: www.ssa.gov

If You Have Access to the Internet, Visit Our Web Site to Change Your Option

- The State Health Benefit Plan:
www.statehealth.org
— If you want to make changes to your SHBP coverage, you can do so online at our Web site. If you decide to change your health coverage option, you can visit www.statehealth.org between April 16, 2001 and May 15, 2001 to make your option change.

If You Have Access to the Internet, Visit These Web Sites for More Information

- Medicare or Medicare+Choice:
—www.medicare.gov
- Many HMOs have their own Internet addresses. Check the HMO's enrollment materials for more information and the sites listed on this page.
- The Health Care Financing Administration:
—www.hcfa.gov
- The Social Security Administration:
—www.ssa.gov

Note: During the Retiree Option Change Period—April 16 through May 15, 2001—call volume for these numbers may be high. You may experience time on hold.

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About the Retiree Option Change Period: April 16 Through May 15, 2001



Effective July 1, 2001, the State Health Benefit Plan offers retirees up to 10 different Health Plan options. By carefully reviewing each option, you can select the coverage that best meets your needs. You may voluntarily change your coverage option during this year's Retiree Option Change Period, which takes place April 16, 2001 through May 15, 2001.

We continue to enhance our benefit plan for retirees, and we are excited about the changes and coverage options available to you effective July 1, 2001.

We are pleased to announce that retirees may enroll in the Standard PPO Option, regardless of where they live. New this year, the SHBP awarded a contract to Beech Street Corporation to manage a comprehensive national network of providers outside the state. This national network gives PPO members balance billing protection and reduced out-of-pocket costs when using a participating national provider.

If you are considering PPO coverage, which combines the flexibility of provider choice with the added plus of discounted in-network rates, balance billing protection, and lower premiums, you'll want to remember the 90/80/60 concept.

What Is the 90/80/60 Concept?

Generally, if you select coverage under the Standard PPO Option and choose to seek care from a Georgia/in-network provider, you receive 90% benefit coverage. *Over 3,500 doctors and 19 hospitals have been added to the Georgia network since last year.* Coverage will be at the 90% level for in-network PPO services received in the state of Georgia and the border communities of the Chattanooga, Tennessee area, including Bradley County; and Phenix City, Alabama. If you choose to seek care from an out-of-state/in-network (or *national* network) provider, you receive 80% benefit coverage. You can also choose to seek care from any licensed out-of-network provider, and receive 60% benefit coverage.

In addition to a national service area under the Standard PPO Option, the Plan expanded the list of covered lab work and tests provided under the \$500 per person per year wellness benefit.

Enhancements to the High Option include coverage for preventive (or wellness) care office visits, and an expanded list of medical procedures covered under wellness benefits. Lab work, tests, and immunizations associated with preventive care office visits are covered up to \$200 per person, per Plan Year. Also new is increased coverage for screening mammograms—up \$50 from last year for a total of \$125.

If you are currently covered under an HMO or Medicare+Choice HMO option, you may notice some increases to office visit and prescription drug copayments and service area changes. (Refer to page 58 of this Guide for details on residence requirements. You can contact the HMO directly for more information on HMO benefit coverage.)

Note that the PPO and High Options are available to all SHBP members, but you must live in an HMO or M+C HMO service area to be eligible for coverage under an HMO.

Beginning July 1, 2001, the prescription drug benefit in the Standard PPO, PPO Choice, and High Options has been changed to a copayment program—so you do not have to pay a deductible first or wait for reimbursement.

All of these enhancements, plus other changes described in your Plan documents, become effective on July 1, 2001.

What You Need to Know About the Retiree Option Change Period

During the Retiree Option Change Period, you will have the chance to select from several different coverage options, some of which are only available for members living in specific counties. You can change from *any coverage option to any other option* for which you are eligible.

- If you are entitled to Medicare Part A and enrolled in Medicare Part B and live in certain counties, you have a Medicare+Choice (M+C) option available to you. The SHBP has arranged with Kaiser HMO for the M+C option to include prescription drug benefits that have no annual maximum. The M+C option also has enhancements like an allowance for hearing exams and vision care. *(See page 26 for more details on the M+C option benefit available to you.)*
- If you live in an approved HMO service area, you can select a Health Maintenance Organization (HMO) option. *(You'll find the details on the HMOs beginning on page 16.)*
- You can select coverage under the Standard Preferred Provider Organization (PPO) option.

The Standard PPO is made up of a network of doctors and hospitals that have agreed to provide quality medical care and services at discounted rates. The PPO allows you to select health care services for yourself and your eligible family members from either inside or outside the provider network. Although you must use network providers to receive the highest level of benefit coverage, you can choose out-of-network providers and receive a reduced level of benefit coverage. The PPO option is available to all members, regardless of your residence. *(You'll find the details on the Standard PPO Option beginning on page 19.)*

- You can select a Consumer Choice Option for HMOs or the Standard PPO. Only providers located and licensed in Georgia may be nominated. *(See pages 18 through 20 for details on your Consumer Choice options.)* Note: Consumer Choice is not available for the M+C HMO plan.

- Or, you can select coverage under the High Option. *(Details on the High Option begin on page 22.)*

All retirees, including surviving spouses of members and direct pay members who are currently covered, can change options during the Retiree Option Change Period—April 16 through May 15, 2001.

The decision you make (for yourself and your family) during this period will become effective on July 1, 2001 and remain in effect through June 30, 2002. Changing options during the year is allowed only under limited circumstances.

What You Need to Do Before May 15, 2001



First: Read This Comparison of Retiree Options

What's in This Guide

- This Guide compares your retiree health coverage options: Medicare+Choice, HMOs, PPOs, and High Option. It outlines the options that are available to you and offers specific information on each. Read it carefully and use it to help you decide which coverage option is best for you and your family.
- As you read through this Guide, you may come across health insurance terms and acronyms you don't know or haven't seen before. The Glossary beginning on page 65 offers quick definitions.

Second: Gather Any Additional Information You May Need

What You Need to Do

You'll want to gather all the necessary information available to make an informed decision.

- Determine the options for which you may be eligible and review the enclosed Rate Worksheet to determine the premiums for those options.
- If you are entitled to Medicare Part A, are enrolled in Medicare Part B, and are interested in selecting the M+C option, contact the Kaiser M+C HMO directly or return the reply card to request a list of providers and other necessary paperwork. For example, if you select the Kaiser M+C option, you are required to complete a separate M+C HMO enrollment form. This form will be included with the information the Kaiser M+C HMO sends to you. Refer to the inside front cover of this Guide for phone numbers and Web addresses to Kaiser. Also, see the information beginning on page 58 for the service area to find out whether or not the Kaiser M+C HMO serves your county of residence.
- So you'll have time to choose your PCP (Primary Care Physician), *call, return your HMO reply card, or visit the HMO's Web site early* to request information from the M+C HMO if you are interested.
- If you are interested in selecting a *regular* HMO option, contact the HMO(s) that serves your county of residence directly to request a list of providers. Refer to the inside front cover of this Guide for phone numbers and Web addresses to the HMOs. Also, see the information beginning on page 59 to find out which HMOs serve your county of residence. Or, you can request information from the HMO(s) by returning the reply card(s) that are enclosed with this packet.
- If you are interested in selecting an M+C or regular HMO for your medical coverage, you'll need to designate a Primary Care Physician (PCP) for each covered person. The HMO directory of network providers (contained in the information you'll receive from the HMO) will help you select your PCP. You may find that your current doctor is a member of an HMO network. So you'll have time to choose your PCP, *call, return your HMO reply card, or visit the HMO's Web site early* to request information from the HMOs in which you are interested. Refer to the information on page 7 for some things you'll want to consider if you're choosing a PCP.
- If you want more information about your HMO or Medicare+Choice HMO coverage options, please call the HMOs directly.
- If you are interested in selecting the Standard PPO Option, you can go online to www.healthygeorgia.com to find a listing of MRN/Georgia 1st providers located in Georgia and a link to a listing of Beech Street providers located across the country. Please be aware that even though Beech Street has providers listed in Georgia, they are not contracted to provide services to SHBP. You may also call the Retiree Help Line at (800) 230-2291 to discuss Georgia service area providers or to request

a printed directory. Contact member services if you would like a printed directory of Beech Street providers in a particular area. Note: Online provider information is the most up-to-date.

- If you need more information on how to gather additional information to help you make your coverage option decision, you can call the Retiree Help Line at (800) 230-2291 for further assistance. Help Line representatives will be available to answer your questions between 8:00 a.m. and 6:00 p.m. Eastern Time, Monday through Friday. *Note: This special Retiree Help Line is available only during the 2001–2002 Retiree Option Change Period. Afterwards, please call the member services number listed on the inside front cover of this Guide.*
- Retiree meetings will be held throughout Georgia during the Retiree Option Change Period. SHBP representatives will be available in various locations to provide additional information and answer your questions. See the enclosed list of meeting dates and locations.

Third: If After Considering Your Choices You Want to Continue in Your Current Option

What You Need to Do

- If you are currently covered under the Standard PPO and do nothing, your coverage (for yourself and any currently covered family members) will be automatically continued under the Standard PPO.
- If you are currently covered under the High Option and do nothing, your coverage (for yourself and any currently covered family members) will be automatically continued under the High Option.
- If you are currently covered under an M+C or regular HMO, refer to the updated residence requirement charts on pages 58-61 of this Guide (or in the enclosed UPDATER) to see if the HMO is still available in your area. If so, and you do nothing, your current coverage will be automatically continued. If the HMO is no longer available, and you do nothing, your coverage will be automatically continued under the Standard PPO.

- If you need more information on how to continue your current coverage, you can call the Retiree Help Line at (800) 230-2291 during the Retiree Option Change Period for further assistance. After May 15, you may contact the appropriate member service numbers. (*See the inside front cover of this Guide.*)

Fourth: If You Decide to Change Your Coverage Option

What You Need to Do

If you decide to change your coverage option, follow these steps:

- If you are eligible to select the Kaiser Medicare+Choice HMO for coverage and you have called the HMO to request the necessary paperwork:
 - There are two forms to complete—one that you received from the SHBP in this packet and one that you received from the M+C HMO.
 - Each individual who is enrolled in Medicare must fill out the enrollment application for the M+C option if you want to join. Send the completed enrollment application to the HMO using their return envelope.
 - Fill out the M+C enrollment application, review and initial the statement of understanding for the M+C option. If you have family coverage, each Medicare enrolled dependent must complete an M+C form. Send the completed enrollment application to the Kaiser M+C HMO using their return envelope.
 - If you select the Kaiser M+C HMO, you must also choose a Primary Care Physician (PCP). Indicate your choice of PCP in the space provided on the enrollment form.
 - Also complete the Personalized Change Form (PCF) enclosed with this packet to indicate your new option selection and to authorize the appropriate change to the deduction from your retirement check. Check the Health Plan option of your choice from the “Options Available” box on your Personalized Change Form.

- If you want to continue coverage for dependents covered under your current Health Plan option, check the box marked “yes” on your PCF. Check the box marked “no” if you want to discontinue coverage for any dependent. *Remember, if you check “no” you won’t be able to reenroll the dependent at any time in the future.*
- If you select a regular HMO for (single or family) coverage and you have called the HMO to request the necessary paperwork:
 - Complete the Personalized Change Form (PCF) enclosed with this packet to indicate your new option and to inform the SHBP how to change your retirement check deductions. Check the Health Plan option of your choice from the “Options Available” box on your Personalized Change Form.
 - Remember, if you select a regular HMO, you must also choose a Primary Care Physician (PCP). Indicate your choice of PCP in the space provided on the Personalized Change Form.
 - If you want to continue coverage for dependents covered under your current Health Plan, check the box marked “yes” on your PCF. Check the box marked “no” if you want to discontinue coverage for any dependent. *Remember, if you check “no” you won’t be able to reenroll the dependent at any time in the future.*

Note: *If you have family coverage, the individual(s) not eligible for the Kaiser M+C option will automatically be enrolled in the regular Kaiser HMO option.*

Fifth: Inform the SHBP (and the Medicare+Choice HMO, if Elected) of Your Coverage Decisions

What You Need to Do

- Complete your PCF to change from any current coverage option into another.
- If you want to continue coverage for dependents, check the box marked “yes” on your PCF for each dependent listed. Check the box marked “no” if you want to discontinue coverage for any dependent. *Remember, if you check “no” you won’t be able to reenroll the dependent at any time in the future.*
- Make a copy of your PCF for your records as your confirmation of option change.
- Sign and return your completed PCF in the envelope addressed to:
 - InktelBCS
13975 N.W. 58th Court
Miami Lakes, FL 33014
- Your envelope must be postmarked no later than May 15, 2001.
- OR, you can change your coverage option by entering the action on the State Health Benefit Plan Web site, www.statehealth.org. The Web site will be available beginning April 16, 2001, and will remain open through May 15, 2001. Web site instructions will guide you through the process.
- If you are selecting the Kaiser M+C HMO, return the separate form that the HMO supplied to you to ensure that you are in compliance with Medicare requirements.
- If you need more information on how to inform the HMO and the SHBP of your option change decision, you can call the Retiree Help Line at (800) 230-2291 for assistance. The Help Line is available April 16, 2001 through May 15, 2001.

Confirmation of Your Option Change

- If you changed coverage to the Kaiser M+C HMO and you filed your M+C form with the HMO:
 - The Kaiser M+C HMO will issue you a temporary ID card or letter which serves as a *conditional* acknowledgement from the HMO that you have elected to enroll. Use this temporary ID card or letter starting on July 1, 2001, and until you receive your permanent ID card so that you will not have any problem obtaining service.
 - Once Medicare approves your application, you will receive confirmation of coverage from the Kaiser M+C HMO. You will receive a new ID card either with the confirmation of coverage, or a few days later. Please review the information on the ID card for accuracy.
- If you make changes to your current coverage by mail, you will receive a new ID card by mail around July 1, 2001. Your new ID card will confirm your election. It will confirm your health care option for Plan Year 2001 – 2002.
- If you make changes to your current coverage online using the SHBP Web site, you will be able to print a confirmation of your option change directly from the Web site. If a printer is not available to you, simply write the confirmation number you'll see on your computer screen in the space provided on your PCF.
- In each case, review your PCF as soon as you get it to make sure it's accurate. If your address is incorrect, mark through the address on the form and write in the correct address. If other errors are shown on the form, contact the Retiree Help Line at (800) 230-2291 to correct them.

A Very Important Note!

If you have medical coverage under another plan, like your spouse's medical plan, you may decide not to choose medical coverage with the State. But remember: **If you choose "No Coverage" for Plan Year 2001, you will not be able to reenroll in an SHBP option at any time in the future, unless you return to active employment with the State in a benefits-eligible position.**

A Word About Physician Credentialing

The HMOs carefully consider physician credentials before accepting them into the networks. The credentialing process is a rigorous evaluation, which includes site visits and direct malpractice and license verifications. HMO network physicians must meet high quality standards, agree to discounted fee arrangements, and participate in ongoing quality review procedures.

Choosing a PCP

If you decide to enroll in the HMOs or the Medicare+Choice HMO option, you must select a Primary Care Physician for each covered person. Follow this process when choosing a PCP:

- Decide which HMO or M+C option(s) you are interested in considering. (Review the Benefits Comparison chart in this Guide to see the major Plan provisions available for each option.)
- Call the HMO or M+C HMO telephone number(s) listed on the inside front cover of this Guide for the option(s) you want to consider and ask for an information package. The HMO will mail you one or more directories of network providers.
- Your current physician may participate as a primary care physician in the HMO network you're considering. But, if you must choose a new doctor, call the doctor's office and ask these questions:
 - Are your locations convenient to me?
 - What are your regular office hours?
 - Are appointments always necessary, or are "walk-ins" welcome?
 - How long does it take to get an appointment for an illness or for an urgent situation?
 - How long does it take to get an appointment for a physical or other routine visit?
 - How can I get in touch with the doctor after hours?
 - Who treats patients if the doctor is unavailable?
- You *must* select a PCP to enroll for coverage under an HMO. And it could take several days to receive provider directories if they will be mailed to you. *So call, return your HMO reply card, or visit the HMO's Web site early to request provider information!*

FIVE STEPS TO SAFER HEALTH CARE

1. Speak up if you have questions or concerns.

Choose a doctor who you feel comfortable talking to about your health and treatment. Take a relative or friend with you if this will help you ask questions and understand the answers. It's okay to ask questions and to expect answers you can understand.

2. **Keep a list of all the medicines you take.** Tell your doctor and pharmacist about the medicines that you take, including over-the-counter medicines such as aspirin, ibuprofen, and dietary supplements like vitamins and herbals. Tell them about any drug allergies you have. Ask the pharmacist about side effects and what foods or other things to avoid while taking the medicine. When you get your medicine, read the label, including warnings. Make sure it is what your doctor ordered, and you know how to use it. If the medicine looks different than you expected, ask the pharmacist about it.
3. **Make sure you get the results of any test or procedure.** Ask your doctor or nurse when and how you will get the results of tests or procedures. If you do not get them when expected—in person, on the phone, or in the mail—don't assume the results are fine. Call your doctor and ask for them. Ask what the results mean for your care.
4. **Talk with your doctor and health care team about your options if you need hospital care.** If you have more than one hospital to choose from, ask your doctor which one has the best care and results for your condition. Hospitals do a good job of treating a wide range of problems. However, for some procedures (such as heart bypass surgery), research shows results often are better at hospitals doing a lot of these procedures. Also, before you leave the hospital, be sure to ask about follow-up care, and be sure you understand the instructions.
5. **Make sure you understand what will happen if you need surgery.** Ask your doctor and surgeon: Who will take charge of my care while I'm in the hospital? Exactly what will you be doing? How long will it take? What will happen after the surgery? How can I expect to feel during recovery? Tell the surgeon, anesthesiologist, and nurses if you have allergies or have ever had a bad reaction to anesthesia. Make sure you, your doctor, and your surgeon all agree on exactly what will be done during the operation.

Source: The Quality Interagency Coordination Task Force (QulC)

Summary of Your Coverage Options



HMO Options	Standard PPO Option	High Option
<p>Medicare+Choice HMO You have one Medicare+Choice HMO option. The Kaiser Permanente M+C HMO provides comprehensive coverage for medical services for Medicare+Choice enrolled persons at lower premiums and higher benefits than those offered under the regular HMOs.</p> <p>You must live in the approved M+C HMO service area to be eligible for coverage. <i>The Kaiser M+C HMO is available to members in the Metro Atlanta service area.</i></p> <p>Regular HMO Options You have three regular HMO options, each offering different benefits—Aetna US Healthcare, BlueChoice, and Kaiser Permanente. Coverage availability varies by HMO and you must live in the approved HMO service area to be eligible for coverage.</p>	<p>Available to anyone eligible for SHBP coverage.</p>	<p>Available to anyone eligible for SHBP coverage.</p>
<p>You receive coverage when in-network providers are used for covered services. In most cases, services are not covered outside of the HMO's provider network, except for emergency or acute care.</p>	<p>You can choose providers who participate in the network and receive a higher level of benefit coverage.</p> <ul style="list-style-type: none"> • If you choose a Georgia service area network provider you generally receive 90% benefit coverage. 	<p>Except for behavioral care and transplants, coverage levels are not based on a provider's network participation. Non-participating providers may balance bill.</p>

HMO Options	Standard PPO Option	High Option
	<ul style="list-style-type: none"> • If you choose an in-network/out-of-state provider, you generally receive 80% benefit coverage. • You can choose out-of-network providers and generally receive 60% benefit coverage. 	
<p>You are required to select a Primary Care Physician and in most cases you need a referral to see a specialist.</p>	<p>You are not required to select a Primary Care Physician and you do not need a referral to see a specialist.</p>	<p>You are not required to select a Primary Care Physician and you do not need a referral to see a specialist.</p>
<p>Generally, there are no deductibles to pay.</p>	<p>For selected services, you must meet deductibles before benefits are payable.</p>	<p>You must meet deductibles before most benefits are payable.</p>
<p>In-network office visit copayments.</p>	<p>In-network office visit copayments. Office visit copayments are not subject to a deductible.</p>	<p>Office visit copayments are not available. Charges are subject to deductibles and coinsurance amounts.</p>
<p>You have in-network coverage for preventive care, including coverage for office visits.</p>	<p>You have coverage for age-appropriate preventive care office visits subject to copayments. Associated lab work and tests are covered in full with no deductible, up to the annual limits.</p>	<p>You have coverage for age-appropriate preventive care office visits subject to general deductible and coinsurance. Associated lab work and tests are covered in full with no deductible, up to the annual limits.</p>
<p>Coverage out-of-state is generally restricted to acute and emergency care.</p>	<p>You have in-network coverage available for participating out-of-state providers in selected areas across the country.</p>	<p>You have coverage for out-of-state providers; however, charges over allowed amounts are balance billed, if services are from non-participating providers.</p>

HMO Consumer Choice Options	PPO Choice Option	High Option
Each of the three regular HMO options has a respective HMO Consumer Choice Option. Eligibility rules are identical to the regular HMO option.	Available to anyone eligible for SHBP coverage. Only providers located and licensed in Georgia may be nominated.	A "Consumer Choice Option" does not apply to the High Option.
Within the respective HMO, benefits are identical to regular HMO option benefits.	Benefits are identical to Standard PPO Option benefits.	
Higher premiums than respective regular HMO option coverage.	Higher premiums than Standard PPO Option coverage.	
Contact HMO to get details on the paperwork and procedures required to nominate a provider.	Contact member services to get details on the paperwork required to nominate a provider.	
You may nominate an out-of-network provider located and licensed in Georgia to be treated as an HMO network provider. The provider must accept your nomination, meet the HMO's requirements, and accept the fee schedule before in-network coverage is available. If the provider nomination is rejected, services from that provider are not covered.	You may nominate an out-of-network provider located and licensed in Georgia to be treated as a PPO network provider. The provider must accept your nomination, meet the PPO's requirements, and accept the fee schedule before in-network coverage is available. If the provider nomination is rejected, out-of-network benefit coverage is available from that provider.	

For more detailed descriptions of your medical coverage options, see the information beginning on page 13 of this Guide.

If You're Entitled to Medicare Part A and Enrolled in Part B, You May Be Eligible to Choose the M+C Option



If you reside in the approved M+C counties in the metro Atlanta area and have full Medicare coverage, you can choose the Kaiser M+C option during the Retiree Option Change Period beginning April 16, 2001. Your M+C medical coverage would become effective July 1, 2001.

What Is Medicare?

Medicare is a national health insurance program for people who are age 65 or older, certain younger disabled people, and people with permanent kidney failure who need dialysis or a transplant. Traditional Medicare is divided into two parts: Hospital Insurance Benefits (Medicare Part A) and Supplementary Medical Insurance Benefits (Medicare Part B). If you are eligible for Medicare, your premiums and benefit coverage level under the SHBP will be affected. As you or your spouse approach age 65, the SHBP will send a letter to inform you of the actions you need to complete in order to maximize your benefits and minimize your costs.

Medicare Part A

If you are age 65 or older and have filed an application for monthly Social Security benefits, you are automatically enrolled in Medicare Part A. There is no cost for Medicare Part A (if you are eligible).

Medicare Part A provides you with Hospital Insurance Benefits. It covers expenses for care received in such health care institutions such as hospitals and skilled nursing facilities. Most people become eligible for Medicare Part A when they reach age 65 *and* are eligible for monthly Social Security retirement or survivor benefits. People who are younger than age 65 and are entitled to disability benefits from Social Security also are eligible for Medicare Part A, usually after 24 months of disability.

Medicare Part B

Medicare Part B covers doctors' services, outpatient services, medical supplies, and other services.

In general, you pay an annual deductible and 20% coinsurance for these services. Medicare pays the rest of the approved amount. People entitled to Medicare Part A are also eligible for Medicare Part B coverage. People who are younger than age 65 and are entitled to disability benefits from Social Security also are eligible for Medicare Part B, generally after 24 months of disability.

If you want Part B, you must *enroll* for Medicare Part B. You are not automatically enrolled. If you did not sign up for Medicare Part B and would like to, call your local Social Security Administration office to find out how. (*The phone number is listed on the inside front cover of this Guide.*)

You pay a monthly premium for Medicare Part B. This premium is generally deducted from your monthly Social Security benefit.

What Is Medicare+Choice?

A third part, Medicare+Choice, offers alternatives to traditional Medicare. It is a product structured in conjunction with an HMO where Medicare pays a premium to the HMO to provide all of your health care services. Refer to the information on page 16 for more details on Health Maintenance Organizations.

Who Is Eligible?

- If you are age 65 or older (or considered long-term disabled by the Social Security Administration), you are eligible for Medicare benefits.
- If you are entitled to Medicare Part A, are enrolled in Medicare Part B, and live in the Kaiser M+C HMO service area, you are eligible to elect the Kaiser M+C HMO.
- Special note on exceptions: Refer to page 15 for conditions which may render you ineligible for coverage under an M+C HMO.

Regarding Your Spouse or Other Dependents

If you enroll in the M+C HMO:

- Your spouse or other dependents that are eligible for Medicare also must enroll in the M+C HMO.
- Your spouse or dependents who are not eligible for Medicare will automatically be placed in the *regular* HMO. Dependents are not eligible to select a different option.

(If you want additional details on your Medicare benefits, contact the Social Security Administration. The phone number and Web site are listed on the inside front cover of this Guide. If you want additional details on your M+C benefits, contact the Kaiser M+C HMO.)

A Detailed Description of Medicare+Choice



How Medicare+Choice Affects Your Current Medicare Coverage

It's important to note that your benefits will be greater than regular HMO benefits as long as you continue to pay your Medicare Part B premiums.

If you choose the Kaiser M+C option, your new coverage will replace your traditional Medicare coverage. Your claim forms will no longer be filed with Medicare and the SHBP. All of your services and payments would be coordinated through the Kaiser M+C HMO.

Your Choice	How Medicare Works	How SHBP Benefits Work
If you choose traditional Medicare (Part A and Part B) as your current retiree medical coveragethen, traditional Medicare becomes your primary plan and pays your medical benefits first.	<p>And your SHBP benefits pay secondary benefits up to the allowed amount for Medicare Part A and Part B coverages.</p> <p>Therefore, the SHBP takes into account what it would have paid and the portion not paid by Medicare to determine if an additional benefit is due from the SHBP. In other words, when Medicare is coordinated with the SHBP, you have 100% coverage on allowed amounts after deductibles for eligible services.</p>
Your Choice	How Medicare Works	How SHBP Benefits Work
If you choose the Kaiser M+C option offered by the SHBP...	...then, traditional Medicare no longer processes your claims. Your Medicare coverage will pay a portion of the HMO premium.	And your SHBP benefits will pay an additional portion of your HMO premium, making coverage generally less expensive than other coverage options.

Advantages and Other Considerations for the Medicare+Choice HMO

Medicare+Choice HMOs are HMOs for Medicare enrolled people. They are similar to regular HMOs (as described on page 16).

Advantages

- They provide a full range of medical and health care services to their members.
- Some benefits, such as prescription drugs, vision care, and preventive care that are not covered by Medicare are included in the M+C HMO offered through the SHBP.
- Note: The Kaiser M+C HMO option offered through the SHBP has the same prescription drug benefit as the regular Kaiser HMO, which has no annual maximum benefit for drugs.
- When a member needs health care services, usually there is only a small copayment for office visits and prescription drugs.
- There are usually no claims to file.

Other Considerations

- If you are eligible and enroll in the Kaiser Medicare+Choice option, you will continue to pay the Medicare Part B premium, usually deducted from your monthly Social Security benefit checks. Your coverage will be based on the rules of the M+C option, which can offer you the advantages of lower out-of-pocket costs, and other conveniences, like reduced paperwork. Medicare pays a portion of your premium directly to the HMO.
- You also will pay an SHBP premium, but it will be lower than regular HMO option coverages.
- See your Rate Worksheet to determine the premium that will be deducted from your retirement check.
- The Kaiser M+C provider network is not the same as the regular HMO network. Be sure to read the M+C provider directory or look at the directory online.

- The Kaiser M+C HMO is made up of a network of physicians and health care providers who offer services through negotiated payment arrangements. As with the regular HMO, you *must* select a Primary Care Physician (PCP) to administer or arrange your care. For most care, you also must get referrals to see specialists.
- In exchange for the lower out-of-pocket costs and infrequent or no claim filing, people enrolled in an M+C HMO must receive all their health care services from an HMO provider to receive a benefit, except in the case of emergency and acute care.
- If you go outside the network, there are usually no benefits, except in the case of an emergency or acute care. Other exceptions to covered services include follow-up care and renal-dialysis care when traveling outside the service area for any length of time.

Can I Be Denied Enrollment in a Medicare+Choice HMO?

The Health Care Financing Administration (HCFA)—the government agency responsible for the administration of the Medicare program—may deny your enrollment in the M+C HMO under these conditions:

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

Note: If you are already enrolled in another M+C HMO and join a new one through the SHBP, Medicare will automatically disenroll you from the former M+C HMO option and enroll you into the M+C option offered through the SHBP.

If you are not approved for the Medicare + Choice Option by HCFA, you will be placed in the respective, regular HMO option. And your premiums will be adjusted to the regular HMO option rates.

What if I Live Outside My Medicare+Choice or Regular HMO Service Area Temporarily?

If you reside in a different area of the country for an extended period, the M+C HMO may not be the best choice for you. Remember that services are available only within the HMO's service area, except for emergency and acute care, follow-up care, and renal-dialysis care. *(If you decide to consider the M+C HMO for your health care coverage, call the HMO directly to request more information. Refer to the contact numbers on the inside front cover of this Guide.)*

HMO Option Details



A Health Maintenance Organization (HMO) is an organization that seeks to maintain the health of its members by delivering comprehensive medical care on a prepaid basis. You can select an HMO option if it's available in your county of residence. (See page 59 for the service area chart.)

Remember: If you are enrolled in Medicare, you may be eligible for coverage under Medicare+Choice. (See the information on Medicare+Choice beginning on page 11 of this Guide.)

Retirees within HMO service areas are generally offered 100% coverage and limited out-of-pocket costs if they select doctors and hospitals in the HMO or M+C HMO network. The Primary Care Physician (PCP) provides most routine care and makes referrals to network specialists as necessary. You must select a PCP for each covered family member at the time of your option change.

Network doctors and hospitals provide comprehensive health care services to members. You pay a small copayment for office visits. But members *must* stay within the network to receive any benefit. If you go to a physician outside the HMO network without a referral from your PCP, the HMO pays *no* benefit for such services unless services are provided due to an emergency. Consequently, if you enroll in the HMO or M+C HMO, you are making a decision for the Plan Year to use the HMO's providers and to follow the HMO's procedures for referrals to receive benefits.

If you join an HMO, you *must* choose a PCP for yourself and each covered family member. Choose from a list of HMO-affiliated participating physicians in private practice, or among HMO-paid staff physicians who practice from the HMO's own health center. (Provider directories are available by sending in the HMO reply cards in this package or by calling the HMO directly. You also can learn about the provider network if you visit the HMO Web sites. Refer to the inside front cover of this Guide for phone numbers and Web addresses.) From that point on, all of your family's

medical care will be coordinated by that physician—either at his or her office, or from a centralized center. (See the information on page 7 for questions you might want to ask a doctor or doctor's office manager if you need to select a PCP.)

Advantages of HMO Options

- You'll have low-cost access to the many services the HMO offers in preventive health care, including physical exams, immunizations, and tests. Access to wellness benefits such as classes on healthy living, smoking cessation, weight control, control of diabetes, and control of high blood pressure is also available. Most medical services that you receive are covered at 100% after you pay a small copayment.
- You'll have small prescription drug copayments.
- Generally, you won't have to file any claims. Paperwork usually enters the picture only for services received outside the HMO's service area.
- In most cases, HMOs do not have deductibles, coinsurance or lifetime benefit maximums, so you'll have low out-of-pocket costs.
- You'll know in advance how much your cost for a visit or treatment is going to be.
- There are no preexisting condition limitations or lifetime benefit maximums.

Since an HMO pays benefits only if provided in the HMO service area, what happens if I'm out of that area and need health care?

For emergencies, seek treatment, contact your PCP or have someone else contact your PCP for you as soon as practical. HMOs cover emergency care as if you were inside their network. Routine (non-emergency) care or services that could have been anticipated are generally not covered outside of your HMO service area. Refer to the HMO's enrollment materials for a definition of emergency care and the claims procedures to follow.

What if I'm unhappy with my Primary Care Physician?

If you are unhappy with your Primary Care Physician, you can change to another Primary Care Physician. The procedure for doing so will vary by HMO, so contact them for assistance.

Other Considerations

- HMOs require you to choose a Primary Care Physician (PCP) and, in most cases, a referral by the PCP is required for coverage of specialty care.
- All HMOs require you to use participating doctors; some require you to use their health center facilities. In most cases, the HMO does not offer any coverage outside of the HMO's provider network. Other than for emergency care or acute care, you will receive no benefits outside the HMO network. If you have a family doctor who isn't participating with an HMO, joining an HMO would force you to end that relationship and choose another physician.
- You may be required to follow the HMO's standardized treatment plan for your condition. For example, you may be required to receive treatment from your PCP for a specified period before getting a referral to see a specialist.
- If you join an HMO, and your PCP or specialist decides to leave the HMO in the middle of a Plan Year, you won't be allowed to leave the HMO or to change options until your next Retiree Option Change Period.
- An HMO's facilities—doctor's office or health center, laboratory, contracting hospital(s)—may be inconvenient for you to visit.
- Some of the doctors affiliated with an HMO may not accept new patients at various times. Check with the physician of your choice before you enroll in an HMO.
- Most HMOs require you to get a referral from your PCP before you visit most specialists—an allergist, orthopedist, or cardiologist, for example. If you do not have referral, the HMO may not pay for the specialist's care.

- You must live in the HMO's service area in order to have coverage under that HMO. If you or your dependent(s) do not live in the HMO's service area, then your eligibility for coverage (or that of a dependent) will be affected. Be sure to contact the HMO to see if any coverage is available outside the service area.

HMO Models—There are two HMO models...

1. **The Group-Practice (GP) model** HMO operates free-standing health centers within a service area. Some of these HMOs also may offer additional provider access through affiliated community physicians, making it more convenient for you to see your doctor. You choose among the physicians who practice in a health center or who are affiliated with the HMO. If your doctor decides you need to be hospitalized, he or she will refer you to a contracted hospital. There you'll be given covered medically-necessary care, including the services of specialists—all monitored by your HMO physician.
2. **The Individual-Practice Association (IPA) model** HMO operates under the terms of a contract with individual practicing physicians. Each IPA doctor maintains a private practice, treating HMO members there and billing the HMO for his or her services to members. If your doctor decides you need hospitalization, you'll be referred to an institution that contracts with the HMO—and where your HMO physician has admitting privileges. There you'll be given covered medically-necessary care, including the services of specialists—all monitored by your HMO physician.

If you join an HMO, you (and each covered member of your family) must select a primary care physician. You'll choose from a list of HMO-affiliated *participating* physicians in private practice, or among HMO-paid staff physicians who practice from the HMO's own health care center. From that point on, each family member's health care will be coordinated by his or her own Primary Care Physician. Generally, you'll find that HMOs utilize hospitalization only when inpatient care is medically necessary.

HMO Consumer Choice Option Details



Each HMO also has a “Consumer Choice Option” available to members at a higher premium. In return for the higher premium, you can request that one or more non-network providers located and licensed in Georgia offer health care services to you and your dependents at the in-network rate. Your request is called a “nomination.” Before you can establish in-network coverage levels from out-of-network providers, the HMO must approve nominations and providers must agree to accept the terms and conditions for network providers, including the network reimbursement rate. Eligible providers include doctors and hospitals and other providers through which the HMO offers coverage.

If the out-of-network provider accepts your nomination and the HMO’s requirements, you may receive in-network benefits from that provider. If your provider does not accept your nomination, does not agree to the HMO’s requirements, or does not accept the HMO’s fees, then services from that provider are not covered.

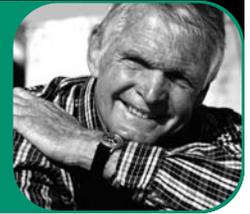
HMO Consumer Choice Option (CCO) benefits are the same as in the respective HMO options; however, HMO Consumer Choice Option premiums are higher. You must contact the respective HMOs directly to find out more about required paperwork and procedures to nominate providers.

Keep in mind: SHBP rules do not permit a member to change benefit plan options when a nominated provider does not accept a nomination. A provider’s rejection by the respective HMO does not allow you to make a change midyear.

- For example, if you elect the Consumer Choice Option, but later learn the doctor you nominated declined to be reimbursed at the network rate, you will not be allowed to change your Health Plan option until the next Retiree Option Change Period.

You will find these options listed on your Personalized Change Form (PCF) as Aetna/US Healthcare CCO, BlueChoice CCO, or Kaiser CCO. Nomination forms are available from the respective HMOs. (*See the inside front cover of this Guide for contact phone numbers and Web sites.*)

Standard PPO Option and PPO Choice Option Details



Standard PPO and PPO Choice Options

The enhanced PPO options consist of a network of participating doctors, ancillary providers, and hospitals that have agreed to provide quality medical care and services at discounted rates. You must use a participating network provider to receive the highest levels of benefit coverage.

The PPO has many of the advantages of an HMO—plus a larger network of participating providers and the flexibility for you to go out-of-network and see non-participating providers at a lower level of benefit coverage. With your out-of-network benefits, you can see any health care provider you like, but with a greater financial responsibility. Whether you see a participating network provider or a non-participating provider, you don't have to choose a Primary Care Physician to direct your care.

Benefit coverage under the PPO option generally will be at one of three levels depending on where you receive care:

- Coverage will be at the 90% level for in-network PPO services received in Georgia and the border communities of the Chattanooga, Tennessee area, including Bradley County; and Phenix City, Alabama. We are pleased to report that over 3,500 doctors and 19 hospitals have been added to the Georgia network since last year. *(See page 56 of this Guide for details on the Georgia service area.)* Providers throughout Georgia participate in the PPO through the MRN/Georgia 1st joint venture.
- Coverage will be at 80% for in-network PPO services received out-of-state. The national PPO network includes a wide range of doctors representing all essential specialties and includes selected hospitals across the country.
- Coverage will be at 60% for out-of-network services received in any area.

Advantages

- The PPO is available to anyone eligible for SHBP coverage.
- You have no claim forms to file when you use participating providers. Participating network providers submit claim forms for you.
- You are not responsible for any amounts above the Plan's allowed amounts when using participating PPO providers. Participating providers cannot "balance bill" members. (See Glossary beginning on page 65.)
- You have access to participating network providers in selected areas, all across the United States. National PPO providers do not balance bill members.
- You have coverage for a wide range of in-network benefits, including annual check-ups, well-baby care, and immunizations.
- Copayments with no deductible for in-network office visits.
- Copayments with no deductible for covered prescription drugs.
- Lower out-of-pocket costs since coinsurance and deductibles are based on negotiated rates with participating providers.
- No in-network deductible to meet for preventive care. Preventive care coverage is based on age schedules and medical history; age schedules are available online at www.healthygeorgia.com or by calling Member Services.

- You have the freedom to choose from the network of participating providers and receive the higher levels of benefit coverage, or to use out-of-network providers and receive a lower level of benefit coverage.
- You have out-of-service area coverage at the in-network benefit level for emergency and acute care. Balance billing is possible.
- You are not required to designate a Primary Care Physician.
- You do not need a referral to see specialists.
- You are not required to precertify care or get prior approvals when using participating Georgia providers. The Georgia PPO provider does this for you. However, this is your responsibility when using non-participating providers and national PPO providers.
- Some of the doctors affiliated with the PPO option may not accept new patients at some times during the year. Check with the physician of your choice before you select the PPO.
- If you use out-of-state or out-of-network providers, you must precertify certain outpatient procedures and all inpatient stays at hospitals. Financial penalties apply if precertification rules are not followed.

PPO Choice Option

The following applies only to the PPO Choice Option.

In return for a higher premium, this option gives members the opportunity to request that an out-of-network provider be treated as an in-network provider. This request is known as a “nomination.” Eligible providers include doctors, hospitals, and other health care providers located and licensed in Georgia for which the PPO offers coverage. If the out-of-network provider accepts your nomination and meets the PPO’s requirements, you will receive in-network benefits from that provider. (However, a provider who accepts your nomination and meets the PPO’s requirements does not become a participating provider with the PPO network.) You may nominate providers at any time during the year if you choose this option during the Retiree Option Change Period. All providers do not have to be nominated immediately during the Change Period.

If your provider does not accept your nomination, does not meet the PPO’s credentialing requirements, or does not accept the network fees, then services from that provider are covered at the lower, out-of-network benefit level. Additionally, you will be required to pay a higher premium—even if the provider elects not to participate or does not meet the PPO’s requirements. SHBP rules do not permit a member to change options when a nominated provider or the PPO rejects a nomination. For further details regarding the nomination process, required paperwork, and procedures, please contact Member Services. The Member Services numbers are on the inside front cover of this Guide.

Other Considerations

- In order to receive the highest level of benefit coverage, the PPO requires you to use the doctors and facilities that are in its network, including hospital-based physicians, laboratories, testing centers, and other ancillary providers. If you have a family doctor who isn’t affiliated with the PPO, coverage for that doctor is available at the lowest level of benefit coverage, which means you’ll have to pay more.
- You may have to submit a claim form if you go out-of-network for services.
- When seeking medical care from a participating network provider, it is your responsibility to check with the PPO to be sure that the provider is participating in the network. You will not receive the higher in-network PPO benefits unless the provider is participating in the PPO network. Also, you can be balance billed by providers who are not participating in the PPO networks.
- If you join a PPO option, and your primary care physician or specialist leaves the network in the middle of a Plan Year, you won’t be allowed to change options until your next Retiree Option Change Period, unless you have a qualifying event, as described in your Plan documents. However, you may choose another in-network provider, or you may still receive lower out-of-network benefits if you continue to see an out-of-network provider.

PPO Choice Option benefits are the same as in the Standard PPO Option; however, PPO Choice Option premiums are higher. The PPO Choice Option service area is the same as the Standard PPO Option. However, even if you live outside of Georgia, you may only nominate providers that are located and licensed in Georgia.

Important Notes

Note on other networks: The Behavioral Health Services (BHS) provider and transplant provider networks are separate from the PPO provider network. To nominate BHS or transplant providers, call the telephone numbers listed on the inside front cover of this Guide.

Note about provider directories: The Georgia PPO provider directory is not included with this package. For the most up-to-date listing of Georgia PPO providers, visit the MRN/Georgia 1st Web site at www.healthygeorgia.com. For the most up-to-date listing of national PPO providers, visit www.healthygeorgia.com and click on the icon for national PPO (Beech Street) providers.

If you don't have Internet access, call member services at the number listed on the inside front cover of this Guide to get provider information.

High Option Details



High Option

The High Option is an indemnity-type benefit program. Coverage is available for medical care given by a qualified medical provider for the treatment of an illness or injury and covered preventive care. High Option members may select any provider they want, but may be balance billed by non-participating providers or for non-covered benefits. Generally, members receive the same coverage level regardless of the provider selected, subject to the Plan's allowed amounts for covered services.

New this year, the High Option includes coverage for preventive (or wellness) care office visits, and an expanded list of medical procedures covered under wellness benefits. Lab work, tests and immunizations associated with preventive care office visits are covered up to \$200 per person, per Plan Year with no deductible. Also new is increased coverage for screening mammograms—up \$50 from last year for a total of \$125.

The High Option has coverage levels similar to in-network/Georgia PPO benefits, but has a higher premium and less coverage for preventive care. High Option also has the same prescription drug copayment program as in the PPO. The High Option is more expensive than any other Plan option.

Also, if you use an out-of-state hospital that does not have a contract with the SHBP, or see a physician in or outside of Georgia who is not in the Participating Physicians Program (PPP), you are subject to balance billing from that provider and could have additional financial responsibilities. Amounts balance billed do not count toward your deductible or out-of-pocket spending limits. You may contact your physician or member services to see if your doctor is in the PPP.

Advantages

- You have freedom to choose any provider.
- As in the PPO options, you are not required to select a Primary Care Physician or get referrals to see specialists.

Other Considerations

- High Option is available to anyone eligible for SHBP coverage.
- Higher premiums than any other option.
- Deductibles for office visits, medical care, and hospitalization must be met before benefits are payable.
- Coverage is available for preventive lab work and tests, subject to allowed amounts and annual maximums. Office visits for preventive care are covered, subject to the general deductible and coinsurance.
- Hospitals that do not contract with the SHBP may balance bill for charges exceeding the Plan's allowed amounts. At present, all general hospitals in Georgia are under contract with the SHBP.
- You must precertify certain outpatient procedures and inpatient stays at non-participating hospitals. Financial penalties apply if precertification rules are not followed.

The “consumer choice option” as described for the Standard PPO Option and HMO options, does not apply to the High Option.

Consider Your Situation



The chart below gives you an at-a-glance view of your personal situation and some of the things you'll want to consider as you make your health coverage option decision.

Your Situation	Your Choices
<p>You're enrolled in Medicare and you are covering yourself only.</p>	<p>Your benefits are designed to coordinate with Medicare, but you must be enrolled in Medicare Parts A and B to achieve maximum benefits.</p> <p>In general, you are eligible to choose:</p> <ul style="list-style-type: none"> • The Medicare+Choice HMO if it's available in your county of residence. • Regular HMOs (if available in your area) • HMO Consumer Choice Options (if available in your area) • Standard PPO (now with participating providers across the U.S.) • PPO Choice • High Option <p>These options coordinate benefits with Medicare.</p> <p><i>(Refer to the tables beginning on page 28 for a comparison of your benefits.)</i></p>
<p>You are not eligible for Medicare and you are covering yourself only.</p>	<p>Since you are not eligible for Medicare, you are not eligible to enroll in an M+C HMO.</p> <p>Coverage options for retired persons who are not enrolled in Medicare include:</p> <ul style="list-style-type: none"> • Regular HMOs (if available in your area) • HMO Consumer Choice Options (if available in your area) • Standard PPO (now with participating providers across the U.S.) • PPO Choice • High Option <p><i>(Refer to the tables beginning on page 28 for a comparison of your benefits.)</i></p>

Your Situation	Your Choices
<p>You are enrolled in Medicare and your spouse or dependent(s) are not.</p>	<p>If you choose the Kaiser M+C HMO option (if it's available in your area), and you are covering your spouse and/or dependents, they are automatically enrolled in the regular (non-Medicare) Kaiser HMO. It is important to note that the benefits and providers available through the regular HMO may differ from those offered by the M+C HMO. Be sure to review the HMO benefits information and provider directories.</p> <p>Other options available to you and your dependent(s) include:</p> <ul style="list-style-type: none"> • Regular HMOs (if available in your area) • HMO Consumer Choice Options (if available in your area) • Standard PPO (now with participating providers across the U.S.) • PPO Choice • High Option <p><i>(Refer to the tables beginning on page 28 for a comparison of your benefits.)</i></p>
<p>You are not enrolled in Medicare and your spouse is.</p>	<p>If you choose the M+C option for your spouse, you are automatically enrolled in the regular, non-M+C HMO. Note: On your PCF you would check the M+C HMO box, even if you would be in a regular HMO.</p> <p>Other coverage options for retired persons who are not enrolled in Medicare include:</p> <ul style="list-style-type: none"> • Regular HMOs (if available in your area) • HMO Consumer Choice Options (if available in your area) • Standard PPO (now with participating providers across the U.S.) • PPO Choice • High Option <p><i>(Refer to the tables beginning on page 28 for a comparison of your benefits.)</i></p>

Your Situation	Your Choices
<p>You and your spouse are both enrolled in Medicare.</p>	<p>Your benefits are designed to coordinate with Medicare, but you and your spouse must be enrolled in Medicare Parts A and B.</p> <p>You can choose the Kaiser M+C HMO if it's available in your county of residence.</p> <p>You also have the following options available to you:</p> <ul style="list-style-type: none"> • Regular HMOs (if available in your area) • HMO Consumer Choice Options (if available in your area) • Standard PPO (now with participating providers across the U.S.) • PPO Choice • High Option <p>These options coordinate benefits with Medicare.</p> <p><i>(Refer to the tables beginning on page 28 for a comparison of your benefits.)</i></p>

Think About Your Needs

As you review all the coverage options available to you, think about your needs:

- What Health Plan option works best, given your budget?
- Are you able to pay deductibles without hardship?
- Are office visit copayments attractive to you?
- Does your current doctor participate in any of the HMO or PPO networks? Is that important to you?
- Is preventive care important to you?

Your answers to questions like these will help you choose the best option for you and your family.

Your Medicare+Choice HMO Benefits



The following chart describes major coverage features of the Kaiser Medicare+Choice HMO option that may be available in your area.

The description does not supersede the actual provisions given in the applicable Plan documents, which are the final authority.

Remember: Certain benefits may or may not be covered, or may have limited coverage, so read this chart carefully. If you need more detailed information, please contact the Kaiser M+C HMO.

BENEFIT OPTION FEATURES	Kaiser Permanente M+C	What's Important to Know About the Medicare+Choice HMO?
Physician Office Visits	\$10 copayment for office visits.	Your office visit copayments for primary care are the same as what you would pay in the regular HMOs, but lower for specialty care office visits.
Hospital Services	Semi-private, ICU, CCU covered at 100%, when authorized by HMO (private room if medically necessary), with no limitation on number of days.	Hospital services are the same as for the regular HMOs.
Inpatient Physician & Surgery and Outpatient Surgery	All physician and surgeon services, including anesthesia and consultation, are covered at 100%.	Surgical care is the same—covered in full—but with no copayment required.
Prescription Drugs	\$10 at Kaiser Permanente medical center pharmacies and \$16 at Eckerd pharmacies. No annual maximum for generic or brand prescription drugs.	Prescription drug coverage is the same as in the regular Kaiser HMO.
Emergency Room (In the Service Area or out of the Service Area)	\$50 copayment, but waived if admitted. \$20 copayments at Kaiser Permanente medical centers after regular office hours.	Emergency room benefits are the same or better than the regular HMO but may vary depending upon the HMO.

(continued on next page)

BENEFIT OPTION FEATURES	Kaiser Permanente M+C	What's Important to Know About the Medicare+Choice HMO?
Behavioral Health Services (BHS)	Mental health inpatient hospital and physician services are covered at 100% coverage for 190 days lifetime. For mental health outpatient services, \$10 copayment for first 8 visits and a \$30 copayment for all subsequent visits.	Your benefits are richer overall—covered at 100% as compared to 80% for regular HMOs— and with fewer limits on visits and duration of care. Depending upon the HMO, your copayment could be the same or less. However, some regular HMO coverage for mental health does not require a copayment.
Hearing Aids/Exam	\$10 copayment for exams; hearing aids are not covered.	These services currently are not offered through the regular HMOs or other SHBP insurance options.
Vision Care	\$15 copayment for annual eye exam; \$40 allowance for frames and no charge for standard lenses; or \$60 allowance for contact lenses (every 24 months).	M+C HMOs provide vision care benefits at low out-of-pocket costs.
Home Health Care	100% coverage for authorized services.	Covered in full for authorized services as in regular HMOs, but depending on the HMO you choose, you may have more covered visits.
Durable Medical Equipment	100% coverage for authorized DME.	Covered in full and same as regular HMOs.
Outpatient Physical Therapy	\$10 copayment for authorized therapy.	Depending upon the HMO you choose, you may have no copayments for outpatient physical therapy, or the same copayment.
Chiropractic Care	\$10 office copayment for each visit for spinal manipulation for subluxation plus coverage for 30 chiropractic visits when approved with \$10 copayment at participating chiropractic offices.	Regular Kaiser HMO coverage for chiropractic care is the same.

If you have specific coverage needs not addressed in this Guide, contact the HMO for assistance. (See the inside front cover of this Guide for phone numbers.)

Comparing Your Benefits



Regular HMO Options, PPO Options, and High Option Benefits

On the following pages, you will find a comparison of benefits for each coverage option under the SHBP except for the Medicare+Choice HMO option benefits which are described on pages 26-27 of this Guide. The purpose of this Guide is to give you a general description of each option and a basis for comparison of the major features.

Contact the member services unit of each option for more details. (*Refer to the inside front cover of this Guide for the list of telephone numbers and Web sites.*) If you need more information on benefit changes in the Standard PPO, PPO Choice, or High Option, call the Retiree Help Line at (800) 230-2291 or refer back to your SHBP booklet dated November 1, 1995 and the subsequent UPDATERS.

Important Notes:

- Deductibles and benefits with annual dollar or visitation limits under the Standard PPO and the High Options are based on the State's fiscal year. The State's fiscal year starts July 1 and ends on June 30 of the following year. This period is also known as the "Plan Year."
- Since "Consumer Choice Option" benefits are the same within each respective HMO and the Standard PPO Option, a separate listing of benefits is not included in the following chart. The respective Consumer Choice Option for each HMO is identified by using the HMO's name followed by the letters "CCO." The PPO Consumer Choice Option is referred to as "PPO Choice."
- Even though each option listed in this Guide provides a broad range of benefits, you should be sure those benefits are compatible with your current personal or family needs. If you have specific coverage needs not addressed in this comparison, then call the appropriate member services number for assistance. See the inside front cover of this Guide for phone numbers.
- Major benefit changes for the upcoming Plan Year are in **bold face type** for each option described in the following comparison chart.

Options/Service Area	Description of Plan
<p>AETNA U.S. HEALTHCARE AETNA U.S. HEALTHCARE CCO</p> <ul style="list-style-type: none"> Atlanta 	<p>An Individual-Practice Association (IPA) Health Maintenance Organization that provides access to comprehensive medical services by private practice physicians who contract with Aetna U.S. Healthcare. All care must be provided or arranged for by an Aetna U.S. Healthcare physician, unless there is a life-threatening emergency.</p>
<p>BLUECHOICE BLUECHOICE CCO</p> <ul style="list-style-type: none"> Atlanta Augusta Macon Savannah 	<p>An IPA Health Maintenance Organization that provides comprehensive medical services, out of individual private practice physician offices. All care must be provided or arranged for by a BlueChoice HMO provider, unless there is a life-threatening emergency.</p>
<p>KAISER PERMANENTE KAISER PERMANENTE CCO</p> <ul style="list-style-type: none"> Atlanta 	<p>A Group Practice (GP) Health Maintenance Organization with additional community physicians that provides various medical services as described. All care must be provided or arranged for by a Kaiser Permanente or Affiliated Community Physician, unless there is a life-threatening emergency. All references to Kaiser Permanente physicians include medical center and Affiliated Community Physicians.</p>
<p>STANDARD PPO PPO CHOICE</p> <p>IN-NETWORK BENEFITS</p> <ul style="list-style-type: none"> Georgia <p>IN-NETWORK BENEFITS</p> <ul style="list-style-type: none"> Out-of-State <p>OUT-OF-NETWORK BENEFITS</p> <ul style="list-style-type: none"> All Areas 	<p>The PPO (preferred provider organization) consists of a comprehensive network of doctors, ancillary providers, and hospitals that have agreed to offer quality medical care and services at discounted rates. You must use a network provider to receive the highest level of benefit coverage. Generally, when you see a participating Georgia provider, your level of benefit coverage is 90% of the allowed amount and when you see a participating national provider, your level of benefit coverage is 80% of the allowed amount. The PPO Option is available to anyone eligible for SHBP coverage.</p> <p>If you choose a PPO, you have the flexibility to go out-of-network for your health care services and receive a lower level of benefit coverage. Generally, when you see an out-of-network provider, your level of benefit coverage is 60% of the allowed amount for non-acute or non-emergency care. With your out-of-network benefits, you can see any qualified provider of medical services. You pay a greater percentage of covered charges for non-acute and non-emergency services if you go out-of-network and you are subject to balance billing for charges above the Plan's Out-of-Network (OON) rate (see Glossary). Balance billing also is possible for acute and emergency services performed by an out-of-network provider.</p>
<p>HIGH OPTION</p> <ul style="list-style-type: none"> All Areas 	<p>A benefit program that provides reimbursement, as described, for the costs of medical care rendered by a qualified professional provider of medical services for treatment related to an illness or an injury and for covered preventive care. While you have the flexibility to receive care from any qualified health care professional, you may be balance billed for charges over the Plan's High Option (H/O) rate (see Glossary) when you use a non-participating provider. The High Option is available to anyone eligible for SHBP coverage.</p>

Options/Service Area	Description of Key Features
<p>AETNA U.S. HEALTHCARE AETNA U.S. HEALTHCARE CCO</p> <ul style="list-style-type: none"> Atlanta 	<p>100% coverage for eligible medical and hospital charges from network providers (unless noted), subject to copayments or coinsurance as indicated. (See Behavioral Health Services.) 100% coverage for eligible physician office visit charges, after copayment. Preventive care covered as indicated. Three-tier copayment program for covered prescription drugs. No deductibles.</p>
<p>BLUECHOICE BLUECHOICE CCO</p> <ul style="list-style-type: none"> Atlanta Augusta Macon Savannah 	<p>100% coverage for eligible medical and hospital charges from network providers (unless noted), subject to copayments or coinsurance as indicated. (See Behavioral Health Services.) 100% coverage for eligible physician office visit charges, after copayment. Preventive care covered as indicated. Two-tier copayment program for covered prescription drugs. No deductibles.</p>
<p>KAISER PERMANENTE KAISER PERMANENTE CCO</p> <ul style="list-style-type: none"> Atlanta 	<p>100% coverage for eligible medical and hospital charges from network providers (unless noted), subject to copayments or coinsurance as indicated. (See Behavioral Health Services.) 100% coverage for eligible physician office visit charges, after copayment. Preventive care covered as indicated. Two-tier copayment program for covered prescription drugs. No deductibles.</p>
<p>STANDARD PPO PPO CHOICE</p> <p>IN-NETWORK BENEFITS</p> <ul style="list-style-type: none"> Georgia 	<p>90% coverage for eligible medical and hospital charges (unless noted), subject to Plan Year deductibles: \$300 per person with a \$900 family maximum. (BHS and transplant services are subject to an additional \$100 hospital deductible. See Behavioral Health Services.) Physician office visits subject to office visit copayments. 100% coverage for eligible preventive lab work and tests, up to \$500 per Plan Year with no deductible. Three-tier copayment program for covered prescription drugs. Stop-loss limits the deductibles and coinsurance to \$1000 of eligible out-of-pocket expenses per person, or \$2000 per family per Plan Year; thereafter, benefits are payable at 100% of eligible charges, unless noted. <i>Ineligible charges, copayments, and MCP penalties do not apply to deductibles or stop-loss limits. Payments made toward deductibles and stop-loss limits do not count toward in-network/out-of-state or out-of-network deductibles and stop-loss limits. Lifetime benefit maximums are combined totals for PPO and High Option. Some annual maximums are combined with in-network/out-of-state and/or out-of-network benefits.</i></p>

Options/Service Area	Description of Key Features (continued)
<p>IN-NETWORK BENEFITS</p> <ul style="list-style-type: none"> • Out-of-State 	<p>80% coverage for eligible medical and hospital charges (unless noted), subject to Plan Year deductibles: \$400 per person with a \$1200 family maximum. (BHS and transplant services are subject to an additional \$100 hospital deductible. See Behavioral Health Services.) Physician office visits subject to office visit copayments. 100% coverage for eligible preventive lab work and tests, up to \$500 per Plan Year with no deductible. Three-tier copayment program for covered prescription drugs. Stop-loss limits the deductibles and coinsurance to \$2000 of eligible out-of-pocket expenses per person, or \$4000 per family per Plan Year; thereafter, benefits are payable at 100% of eligible charges, unless noted. <i>Ineligible charges, copayments, and Medical Certification Program (MCP) penalties do not apply to deductibles or stop-loss limits. Payments made toward deductibles and stop-loss limits are combined with out-of-network deductibles and stop-loss limits.</i></p>
<p>OUT-OF-NETWORK BENEFITS</p> <ul style="list-style-type: none"> • All Areas 	<p>60% coverage for eligible medical and hospital charges (unless noted), subject to Plan Year deductibles: \$400 per person with a \$1200 family maximum. (BHS and transplant services are subject to an additional \$100 hospital deductible. See Behavioral Health Services.) 60% coverage for eligible physician office visit charges after deductible. Preventive care not covered. Three-tier copayment program for covered prescription drugs. Stop-loss limits the deductibles and coinsurance to \$2000 of eligible out-of-pocket expenses per person, or \$4000 per family per Plan Year; thereafter, benefits are payable at 100% of eligible charges, unless noted. <i>Ineligible charges, copayments, and MCP penalties do not apply to deductibles or stop-loss limits. Payments made toward deductibles and stop-loss limits are combined with in-network/out-of-state deductibles and stop-loss limits.</i></p>
<p>HIGH OPTION</p> <ul style="list-style-type: none"> • All Areas 	<p>90% coverage of eligible medical and hospital charges (unless noted), subject to Plan Year deductibles: \$300 per person with a \$900 family maximum. (See Behavioral Health Services.) \$100 inpatient hospital deductible per confinement. 90% coverage for eligible physician office visit charges, including preventive care visits, after deductible. 100% coverage for eligible preventive lab work and tests, up to \$200 per Plan Year, plus an additional amount for specified services with no deductible. Three-tier copayment program for covered prescription drugs. Stop-loss limits the deductibles and coinsurance to \$1500 of eligible out-of-pocket expenses per person, or \$2500 per family per Plan Year; thereafter, benefits are payable at 100% of eligible charges, unless noted. <i>Ineligible charges, copayments, and MCP penalties do not apply to deductibles or stop-loss limits.</i> Lifetime benefit maximums are combined with PPO Option.</p>

Options/Service Area	Providers of Service
<p>AETNA U.S. HEALTHCARE AETNA U.S. HEALTHCARE CCO</p> <ul style="list-style-type: none"> Atlanta 	<p>You and each of your eligible dependents must choose a participating Primary Care Physician from the appropriate Aetna U.S. Healthcare network. For inpatient care, you will be referred to a hospital with which the HMO has contracted for care of its members, and at which your physician has admitting privileges. Prescription drugs are available from any Aetna U.S. Healthcare participating pharmacy. Prescriptions for 90-day supplies of maintenance medications are covered through a mail order program or at participating pharmacies. Members may self-refer to any participating provider for covered OB/GYN, dermatology, vision care, and mental health/substance abuse care.</p>
<p>BLUECHOICE BLUECHOICE CCO</p> <ul style="list-style-type: none"> Atlanta Augusta Macon Savannah 	<p>You and each covered dependent must select a Primary Care Physician. For inpatient care, you will be referred to one of the listed hospitals with which HMO Georgia (BlueChoice HMO) has a contract, and at which your physician has admitting privileges. Prescription drugs may be obtained at any participating BlueChoice pharmacy. Members may self-refer to any participating provider for covered OB/GYN, dermatology, ophthalmology, chiropractic, and mental health/substance abuse care.</p>
<p>KAISER PERMANENTE KAISER PERMANENTE CCO</p> <ul style="list-style-type: none"> Atlanta 	<p>You can choose your physician from either a Kaiser Permanente medical center or from a group of Affiliated Community Physicians practicing in their own office. If you select an Affiliated Community Physician, that doctor or another Affiliated Community Physician who practices in the same office will provide your care. If you decide to receive care from a doctor not practicing in your doctor's office, you will need to contact Kaiser Permanente before receiving treatment to select that individual as your new physician and to have coverage. Your physician choice will determine where you will receive specialty and inpatient care. Prescription drugs are available from Kaiser Permanente medical center pharmacies and participating community pharmacies. Members may self-refer to any participating provider for covered OB/GYN, dermatology, and mental health/substance abuse care.</p>

Options/Service Area	Providers of Service (continued)
<p>STANDARD PPO PPO CHOICE</p> <p>IN-NETWORK BENEFITS</p> <ul style="list-style-type: none"> Georgia <p>IN-NETWORK BENEFITS</p> <ul style="list-style-type: none"> Out-of-State <p>OUT-OF-NETWORK BENEFITS</p> <ul style="list-style-type: none"> All Areas 	<p>You and each covered dependent must use physicians from the PPO network to receive the higher level of in-network benefits. For inpatient care, you must use one of the listed hospitals with which the PPO has a contract and at which your physician has admitting privileges. Prescription drugs may be obtained at any participating pharmacy. Referrals for specialty care are not required. Coverage is available for out-of-state providers in selected areas at in-network benefit coverage levels. Provider directories for the Georgia network are available online at www.healthygeorgia.com or by calling Member Services. Provider directories for the national network are available online at www.healthygeorgia.com or by phone request to the Retiree Help Line. See inside front cover.</p> <hr/> <p>Any lawfully operated hospital, licensed physician, licensed pharmacy, or other qualified provider of medical services. Balance billing may apply.</p>
<p>HIGH OPTION</p> <ul style="list-style-type: none"> All Areas 	<p>Any lawfully operated hospital, licensed physician, licensed pharmacy, or other qualified provider of medical services. Coverage for out-of-state and non-participating providers is subject to balance billing. Referrals for specialty care are not required.</p>

Options/Service Area	Coverage Outside Service Area
<p>AETNA U.S. HEALTHCARE AETNA U.S. HEALTHCARE CCO</p> <ul style="list-style-type: none"> Atlanta 	<p>\$50 copayment for emergency room treatment of acute illness or accidental injury. The copayment is waived if the patient is admitted. Members should seek the nearest medical facility for emergency care.</p>
<p>BLUECHOICE BLUECHOICE CCO</p> <ul style="list-style-type: none"> Atlanta Augusta Macon Savannah 	<p>\$50 copayment for hospital emergency room treatment of acute illness or accidental injury. Copayment is waived if admitted. For urgent care, BlueChoice offers facilities across the U.S. through HMO U.S.A. Members access local networks by calling a national hotline number. A toll-free nurse help-line is available 24 hours per day, 7 days per week. Members with eligible dependents residing anywhere in the continental U.S. where Blue Cross Blue Shield plans have operating HMOs may enroll their dependents in the HMO Guest Membership Program.</p>
<p>KAISER PERMANENTE KAISER PERMANENTE CCO</p> <ul style="list-style-type: none"> Atlanta 	<p>\$50 copayment for hospital emergency room treatment of acute illness or accidental injury, unless patient is admitted. \$25 copayment for outpatient follow-up or continuing medical care when outside of any other Kaiser Foundation Health Plan service area by more than 100 miles. Up to \$500 per calendar year for follow-up care associated with emergency room treatment is covered for members outside the service area. Facilities are located across the U.S.</p>
<p>STANDARD PPO PPO CHOICE</p> <ul style="list-style-type: none"> All Areas 	<p>Emergency or Acute Care Non-participating provider charges for emergency or acute care are covered at the 90% in-network benefit level, subject to the in-network/Georgia deductible and balance billing. \$60 copayment for emergency room treatment of life-threatening emergencies or acute illness/accidental injury. Emergency room copayment is waived if admitted or reduced to \$40 if referred by NurseCall 24. Inpatient admissions and specified outpatient procedures require precertification through the MCP. Services that may not be available through participating network PPO providers must be preauthorized and approved by the Plan to receive in-network benefit coverage levels. NurseCall 24 information service is available toll-free 24 hours per day, 7 days per week.</p>
	<p>Preventive or Planned Care Out-of-network benefit coverage levels apply for services received through a non-participating provider. Preventive care is not covered out-of-network. Charges from providers who are not in the PPO are subject to balance billing. Inpatient admissions and specified outpatient procedures require precertification through the MCP. Nurse-Call 24 information service is available toll-free 24 hours per day, 7 days per week.</p>
<p>HIGH OPTION</p> <ul style="list-style-type: none"> All Areas 	<p>Location does not affect benefit levels or deductibles. \$60 copayment for emergency room treatment of life-threatening emergencies or acute illness/accidental injury. Emergency room copayment is waived if admitted or reduced to \$40 if referred by NurseCall 24. Charges from physicians who are not in the PPP (see Glossary) are subject to balance billing. Charges from non-contracted hospitals are subject to balance billing. Inpatient admissions and specified outpatient procedures require precertification through the MCP. NurseCall 24 information service is available toll-free 24 hours per day, 7 days per week.</p>

Options/Service Area	Physician Visits
<p>AETNA U.S. HEALTHCARE AETNA U.S. HEALTHCARE CCO</p> <ul style="list-style-type: none"> Atlanta 	<p>Office visits for primary care are covered in full after a \$10 copayment and after a \$20 copayment for specialty care. Inpatient physician visits are covered in full. Visits for diagnosis and limited treatment of infertility are covered after a \$20 copayment. Members must contact an infertility case manager before covered care is rendered. Outpatient lab and x-ray outside the physician’s office covered with \$20 copayment. Chiropractic care is covered with a \$20 copayment up to 20 visits per year with a referral from your Primary Care Physician to a participating provider. No referral is necessary for visits to network dermatologists, OB/GYNs, ophthalmologists, optometrists, and mental health providers.</p>
<p>BLUECHOICE BLUECHOICE CCO</p> <ul style="list-style-type: none"> Atlanta Augusta Macon Savannah 	<p>Office visits for primary care are covered in full after a \$10 copayment and after a \$15 copayment for specialty care. Network chiropractors may be visited up to 20 times per policy year subject to a \$15 office visit copayment. No referral is necessary for visits to network dermatologists, OB/GYNs, ophthalmologists, mental health providers, and chiropractors. Inpatient physician visits are covered at 100%.</p>
<p>KAISER PERMANENTE KAISER PERMANENTE CCO</p> <ul style="list-style-type: none"> Atlanta 	<p>Office visits for primary care are covered in full after a \$10 copayment and after a \$15 copayment for specialty care. Visits to our “After Hours” locations are covered in full after a \$20 copayment. Inpatient physician visits are covered in full. Visits for infertility services (diagnosis and treatment) are covered in full after a \$15 copayment (see Exclusions). Outpatient lab and x-ray (except infertility services) are covered at 100%; infertility lab and x-ray are covered in full after a \$15 copayment. \$5 copayment per visit for allergy injections. \$50 copayment for every six-month supply of maintenance serum for allergy care. Up to 30 chiropractic visits per calendar year are covered at participating chiropractic offices after a \$10 copayment; the initial visit does not require a referral, and subsequent visits are covered only when medically necessary. You may self-refer to any participating provider for covered OB/GYN, dermatology, ophthalmology, and mental health/substance abuse care.</p>

Options/Service Area	Physician Visits (continued)
<p>STANDARD PPO PPO CHOICE</p> <p>IN-NETWORK BENEFITS</p> <ul style="list-style-type: none"> Georgia 	<p>Office visits for both primary and specialty care are covered at 100% after a per visit copayment of \$20 is paid. Office visits are not subject to a general deductible. (Also see office visit coverage under Preventive (Wellness) Care.) Inpatient physician visits are covered at 90% of network rate after meeting the general deductible. Certain diagnostic procedures require precertification from the Medical Certification Program (MCP) or reimbursement is reduced. Amounts over the negotiated network rate are not subject to balance billing by the provider.</p>
<p>IN-NETWORK BENEFITS</p> <ul style="list-style-type: none"> Out-of-State 	<p>Same as above except: Inpatient physician visits are covered at 80% of network rate after meeting the general deductible.</p>
<p>OUT-OF-NETWORK BENEFITS</p> <ul style="list-style-type: none"> All Areas 	<p>Office visits and inpatient physician visits are covered at 60% of the out-of-network (OON) rate (see Glossary) after the out-of-network deductible is met. Certain diagnostic procedures require precertification from the MCP or reimbursement is reduced. Amounts over the OON rate are subject to balance billing by the provider.</p>
<p>HIGH OPTION</p> <ul style="list-style-type: none"> All Areas 	<p>Office visits and inpatient physician visits are covered at 90% of the H/O rate (see Glossary) after the general deductible is met. (Also see office visit coverage under Preventive (Wellness) Care). Second opinions are paid at 100%, if recommended by the MCP. Certain diagnostic procedures require precertification through MCP or reimbursement is reduced.</p>

Options/Service Area	Hospital Services
<p>AETNA U.S. HEALTHCARE AETNA U.S. HEALTHCARE CCO</p> <ul style="list-style-type: none"> Atlanta 	<p>Semi-private (private room if medically necessary) upon referral by Primary Care Physician or in an emergency, ICU, CCU, and miscellaneous hospital charges covered in full as approved by the HMO. For complex medical problems where care is not available in the area, the HMO arranges care through the National Medical Excellence Program. Mental health benefits and substance abuse treatments are limited; see Behavioral Health Care.</p>
<p>BLUECHOICE BLUECHOICE CCO</p> <ul style="list-style-type: none"> Atlanta Augusta Macon Savannah 	<p>All hospital services are covered at 100% when authorized by your Primary Care Physician. Mental health and substance abuse benefits have limitations; see Behavioral Health Care.</p>
<p>KAISER PERMANENTE KAISER PERMANENTE CCO</p> <ul style="list-style-type: none"> Atlanta 	<p>Semi-private (private room if medically necessary), ICU, CCU, and miscellaneous hospital charges covered in full as approved by the Medical Group Chief of Quality Resource Management or Chief of Network Services, or their designee. Mental health benefits and substance abuse treatment are limited; see Behavioral Health Care.</p>
<p>STANDARD PPO PPO CHOICE</p> <p>IN-NETWORK BENEFITS</p> <ul style="list-style-type: none"> Georgia 	<p>Semi-private, ICU, CCU, and miscellaneous hospital charges are covered at 90% of network rate subject to general deductible. Balance billing does not apply. In-network hospitals precertify inpatient admissions. General deductible and coinsurance can be applied to the stop-loss limit. Mental health and substance abuse benefits are limited; see Behavioral Health Care.</p>
<p>IN-NETWORK BENEFITS</p> <ul style="list-style-type: none"> Out-of-State 	<p>Same as above with the following exceptions: Semi-private, ICU, CCU, and miscellaneous hospital charges are covered at 80% of network rate subject to general deductible. Members are responsible for precertifying hospital stays at in-network/out-of-state facilities.</p>
<p>OUT-OF-NETWORK BENEFITS</p> <ul style="list-style-type: none"> All Areas 	<p>Semi-private, ICU, CCU, and miscellaneous hospital charges are covered at 60% of the OON rate and are subject to the general deductible. Balance billing may apply. MCP precertification is required or reimbursement is reduced. General deductible and coinsurance can be applied to the stop-loss limit. Mental health and substance abuse benefits are limited; see Behavioral Health Care.</p>
<p>HIGH OPTION</p> <ul style="list-style-type: none"> All Areas 	<p>Semi-private, ICU, CCU, and miscellaneous hospital charges are covered at 90% of the H/O rate after a \$100 hospital deductible is met. Coverage for non-contracted hospitals is subject to balance billing. Hospital deductible is per admission. (Must call MCP or reimbursement is reduced.) Physician charges while an inpatient are subject to the general deductible. Deductibles and coinsurance can be applied to the stop-loss limit. Mental health and substance abuse benefits are limited; see Behavioral Health Care.</p>

Options/Service Area	Surgical Care
<p>AETNA U.S. HEALTHCARE AETNA U.S. HEALTHCARE CCO</p> <ul style="list-style-type: none"> Atlanta 	<p>Inpatient surgery and outpatient surgery are covered in full with a referral from an Aetna U.S. Healthcare participating Primary Care Physician, or in an emergency.</p>
<p>BLUECHOICE BLUECHOICE CCO</p> <ul style="list-style-type: none"> Atlanta Augusta Macon Savannah 	<p>Both inpatient and outpatient surgery are covered at 100% when authorized by your Primary Care Physician.</p>
<p>KAISER PERMANENTE KAISER PERMANENTE CCO</p> <ul style="list-style-type: none"> Atlanta 	<p>Inpatient surgery covered in full, outpatient surgery covered in full after copayment when authorized by the Medical Group Chief of Quality Resource Management or Chief of Network Services, or their designee. Outpatient surgery performed by Primary Care Physician covered in full after \$10 copayment, and after \$15 copayment if performed by a specialist.</p>
<p>STANDARD PPO PPO CHOICE</p> <p>IN-NETWORK BENEFITS</p> <ul style="list-style-type: none"> Georgia <p>IN-NETWORK BENEFITS</p> <ul style="list-style-type: none"> Out-of-State <p>OUT-OF-NETWORK BENEFITS</p> <ul style="list-style-type: none"> All Areas 	<p>90% of the discounted network rate for professional services and associated institutional charges. 10% coinsurance can be applied to the stop-loss limit. Certain outpatient surgical procedures require precertification from the MCP or reimbursement is reduced. Payment for surgical care is subject to the general deductible. Amounts over the discounted network rate are not subject to balance billing by the provider.</p> <p>Same as above except: 80% of the discounted network rate for professional services and associated institutional charges. 20% coinsurance can be applied to the stop-loss limit. Amounts over the discounted network rate are not subject to balance billing by the provider.</p> <p>60% of the OON rate for professional services. 60% of the OON rate for associated institutional charges. 40% coinsurance can be applied to the stop-loss limit. Certain outpatient surgical procedures require precertification from the MCP or reimbursement is reduced. Payment for surgical care is subject to the out-of-network deductible. Amounts over the OON rate are subject to balance billing by the provider.</p>
<p>HIGH OPTION</p> <ul style="list-style-type: none"> All Areas 	<p>90% of the H/O rate for professional services and for associated institutional charges. 10% coinsurance can be applied to the stop-loss limit. Certain outpatient surgical procedures require precertification through MCP or reimbursement is reduced. Payment for surgical care is subject to the general deductible. Amounts over the allowed amount are subject to balance billing by the provider unless you are using a participating provider.</p>

Options/Service Area	Emergency Services
<p>AETNA U.S. HEALTHCARE AETNA U.S. HEALTHCARE CCO</p> <ul style="list-style-type: none"> Atlanta 	<p>\$50 copayment per visit (illness or injury) for emergency room services. Covered when there is a life-threatening emergency or when authorized by your Primary Care Physician. If the emergency results in a hospital admission, the emergency room copayment is waived.</p>
<p>BLUECHOICE BLUECHOICE CCO</p> <ul style="list-style-type: none"> Atlanta Augusta Macon Savannah 	<p>\$50 copayment for outpatient emergency room services when there is a life-threatening emergency, or when authorized by your Primary Care Physician or the on-call nurse. Members may obtain treatment at any licensed medical facility. Copayments are waived if admitted.</p>
<p>KAISER PERMANENTE KAISER PERMANENTE CCO</p> <ul style="list-style-type: none"> Atlanta 	<p>\$50 copayment for emergency room visits or when authorized by a Kaiser Permanente physician. Copayment is waived if admitted. \$50 copayment for emergency ambulance transportation. \$20 copayment at Kaiser Permanente medical center after regular office hours.</p>
<p>STANDARD PPO PPO CHOICE</p> <p>IN-NETWORK BENEFITS</p> <ul style="list-style-type: none"> Georgia <p>IN-NETWORK BENEFITS</p> <ul style="list-style-type: none"> Out-of-State 	<p>\$60 copayment per visit to emergency room; waived if admitted to hospital. If you are referred by the NurseCall 24 information service, the copayment is reduced to \$40; see Wellness Programs. After the emergency room copayment and in-network/Georgia deductible are met, coverage is 90% of network rate for emergency or acute treatment (see Glossary) of illness or injury and for associated expenses. Copayment does not count toward in-network/Georgia deductible or stop-loss. If surgery is performed without being admitted, institutional charges are payable at 90% of network rate, subject to in-network/Georgia deductible. If emergency admission occurs, the MCP must be called within one business day unless at an in-network/Georgia hospital; in-network/Georgia deductible applies. For urgent care in a participating center, coverage is 100% of network rate after a per visit copayment of \$35.</p>
<p>OUT-OF-NETWORK BENEFITS</p> <ul style="list-style-type: none"> All Areas 	<p>\$60 copayment per visit to emergency room; waived if admitted to hospital. If you are referred by the NurseCall 24 information service, the copayment is reduced to \$40; see Wellness Programs. After the emergency room copayment and in-network/Georgia deductible are met, coverage is 90% of network rate for emergency or acute care, subject to balance billing. Copayment does not count toward in-network/Georgia deductible or stop-loss. If surgery for emergency or acute condition is performed without being admitted, institutional charges are payable at 90% of network rate, subject to in-network/Georgia deductible, and to balance billing. If emergency admission occurs out-of-network, the MCP must be called within one business day; in-network/Georgia deductible applies.</p>
<p>HIGH OPTION</p> <ul style="list-style-type: none"> All Areas 	<p>\$60 copayment per visit to emergency room; waived if admitted to hospital. If you are referred by the NurseCall 24 information service, the copayment is reduced to \$40; see Wellness Programs. After the emergency room copayment and general deductible are met, coverage is 90% of H/O rate for treatment of illness or injury and for associated expenses. If outpatient surgery is performed, institutional charges are payable at 90%, subject to hospital deductible. Copayment does not count toward general deductible or stop-loss. If emergency admission occurs, the MCP must be called within one business day unless at a hospital contracting directly with the SHBP; hospital deductible applies. Charges from non-participating providers are subject to balance billing.</p>

Options/Service Area	Prescription Drugs
<p>AETNA U.S. HEALTHCARE AETNA U.S. HEALTHCARE CCO</p> <ul style="list-style-type: none"> Atlanta 	<p>For a 30-day supply of prescription drugs: \$10 copayment per generic formulary prescription or refill; \$15 copayment for brand name formulary; \$30 copayment for non-formulary. Oral contraceptives are covered. Members must use a participating Aetna U.S. Healthcare pharmacy. Prescription maintenance drugs are available up to a 90-day supply for a double copayment through a mail order drug program or at participating pharmacies.</p>
<p>BLUECHOICE BLUECHOICE CCO</p> <ul style="list-style-type: none"> Atlanta Augusta Macon Savannah 	<p>\$10 copayment for up to a 30-day supply of generic prescribed drugs and a \$20 copayment for up to a 30-day supply of prescribed brand name drugs listed in the BlueChoice Health Care Plan drug formulary, filled at any BlueChoice participating pharmacy. All prescriptions must be written by an authorized network provider.</p>
<p>KAISER PERMANENTE KAISER PERMANENTE CCO</p> <ul style="list-style-type: none"> Atlanta 	<p>\$10 copayment for up to the lesser of a 30-day supply or the standard prescription amount of prescribed covered drugs listed in the Kaiser Permanente Drug Formulary, if obtained at a Kaiser Permanente medical center pharmacy; \$16 copayment if obtained at a participating community pharmacy.</p>
<p>STANDARD PPO PPO CHOICE</p> <p>IN-NETWORK BENEFITS</p> <ul style="list-style-type: none"> Georgia (Express Scripts Pharmacy Network) <p>IN-NETWORK BENEFITS</p> <ul style="list-style-type: none"> Out-of-State (Express Scripts Pharmacy Network) <p>OUT-OF-NETWORK BENEFITS</p> <ul style="list-style-type: none"> All Areas (Pharmacy Not In Express Scripts Network) 	<p>\$10 copayment for generic drugs; \$20 copayment for preferred brand-name drugs; 20% coinsurance for non-preferred brand name drugs, with a \$35 minimum and \$75 maximum copayment. When a member chooses a preferred brand name or non-preferred brand name drug over its generic equivalent, the member will be responsible to pay the difference between the two in addition to the generic copayment. If the treating physician mandates the preferred brand or non-preferred brand over the generic, the “pay-the-difference” feature will not apply. The member will be responsible for paying the preferred brand or non-preferred brand copayment amount. If the drug’s usual and customary cost is less than the copayment, the member pays the drug’s usual and customary cost. Copayments are based upon supplies of up to 30 days; some drugs are limited to a standard other than 30-day supplies. You may obtain up to a 90-day supply for your initial prescription and for each refill (if written for 90 days) with one copayment per 30-day supply for drugs listed as maintenance drugs under the Plan. Deductible does not apply to prescription drug benefits.</p> <p>Member must pay charges at point of sale and submit a paper claim with a pharmacy receipt. Members will be reimbursed at the pharmacy network rate less the required copayment for those drugs covered by the Plan. Limitations and restrictions indicated above also apply to covered drugs purchased out-of-network. Charges are subject to balance billing.</p>
<p>HIGH OPTION</p> <ul style="list-style-type: none"> All Areas 	<p>Same as Standard PPO Option.</p>

Options/Service Area	Preventive (Wellness) Care
<p>AETNA U.S. HEALTHCARE AETNA U.S. HEALTHCARE CCO</p> <ul style="list-style-type: none"> Atlanta 	<p>Routine check-ups, well-baby/well-child care, immunizations, lab tests, including screenings for breast and colorectal cancer, routine allergy shots, PAP smears, prostate screening, and GYN exams are covered in full after copayment. Primary care copayments are \$10 per visit and specialty care copayments are \$20 per visit. Program available to identify high-risk pregnancies and promote safe births of healthy babies. First OB visit—\$20 copayment, then covered at 100% for prenatal visits.</p>
<p>BLUECHOICE BLUECHOICE CCO</p> <ul style="list-style-type: none"> Atlanta Augusta Macon Savannah 	<p>Well-baby/well-child care, immunizations, routine check-ups, physical examinations, GYN exams, and mammograms are covered in full after an office visit copayment. Primary care copayments are \$10 per visit and specialty care copayments are \$15 per visit. Depending on age, some routine care is not covered annually.</p>
<p>KAISER PERMANENTE KAISER PERMANENTE CCO</p> <ul style="list-style-type: none"> Atlanta 	<p>Routine check-ups and preventive health screenings (including pap smears and prostate screening exams for adults) are covered in full after a \$10 copayment for primary care and after a \$15 copayment for specialty care. Mammograms are covered at 100%. All prenatal visits and the first postnatal visit are covered at 100%. Well-baby/well-child care and immunizations are covered at 100% up to age 24 months and with a \$10 copayment thereafter.</p>
<p>STANDARD PPO PPO CHOICE</p> <p>IN-NETWORK BENEFITS</p> <ul style="list-style-type: none"> Georgia <p>IN-NETWORK BENEFITS</p> <ul style="list-style-type: none"> Out-of-State <p>OUT-OF-NETWORK BENEFITS</p> <ul style="list-style-type: none"> All Areas 	<p>Physician fees for office visits covered at 100% of network rate after a per visit copayment of \$20. Covered lab work and tests associated with preventive care visits are paid at 100% of the negotiated network rate with no copayment, up to a maximum of \$500 per year per person (at network rate). The \$500 annual maximum for associated lab work and tests applies to such services as: mammograms, PSAs, EKGs, and PAP smears. Coverage is based on age schedules and medical history; age schedules are available online at www.healthygeorgia.com or by calling member services. Routine preventive care is not subject to the general deductible.</p> <p>Not covered. Charges do not apply to general deductible or annual out-of-pocket (stop-loss) limits.</p>
<p>HIGH OPTION</p> <ul style="list-style-type: none"> All Areas 	<p>Physician fees for office visits are covered at 90% of H/O rate after meeting the general deductible. Covered lab work and tests associated with preventive care visits are paid at 100% of H/O rate with no deductible, up to a maximum of \$200 per year per person (at H/O rate). The \$200 annual maximum for associated lab work and tests applies to such services as: PSAs, EKGs, and pap smears. Coverage is based on age schedules and medical history; age schedules are available online at www.healthygeorgia.com or by calling member services. Up to an additional \$125 for screening mammogram. Balance billing may apply unless using a participating provider.</p>

Options/Service Area	Wellness Programs
<p>AETNA U.S. HEALTHCARE AETNA U.S. HEALTHCARE CCO</p> <ul style="list-style-type: none"> Atlanta 	<p>Aetna U.S. Healthcare offers a number of wellness programs: a nutritional program; expectant mother and father programs; and a health education program with brochures on a full range of health related topics. A Web site offers information on wellness programs as well as an interactive feature with health and fitness articles. A 24-hour toll-free Informed HealthLine links members to registered nurses who can provide information and support on a variety of health issues. For more information on additional programs, call Aetna U.S. Healthcare.</p>
<p>BLUECHOICE BLUECHOICE CCO</p> <ul style="list-style-type: none"> Atlanta Augusta Macon Savannah 	<p>A toll-free nurse-help line available 24 hours per day, 7 days per week to answer any health-related questions and to assist Plan participants in determining the most appropriate level of care when medical attention is requested, including emergency room referrals. Telephone access to an extensive library of health related recordings and educational publications mailed to your home are also available. BlueChoice Healthcare Plan also sponsors a number of wellness programs covering nutrition, weight management, health behavior/lifestyle identification, and injury prevention. Member education newsletters are provided quarterly.</p>
<p>KAISER PERMANENTE KAISER PERMANENTE CCO</p> <ul style="list-style-type: none"> Atlanta 	<p>Kaiser Permanente offers a variety of health education programs, publications, and self-care tools. They include over 200 health education classes; a toll-free line members can call to get recorded messages on health topics; a self-care handbook, which includes guidelines on recognizing and treating common health problems; a free confidential interactive Web site offering services, information, and advice from health care professionals 24 hours a day; and a quarterly member magazine containing information on preventive care, medical centers, membership, and health education classes.</p>

Options/Service Area	Wellness Programs (continued)
<p>STANDARD PPO PPO CHOICE</p> <p>IN-NETWORK BENEFITS</p> <ul style="list-style-type: none"> Georgia <p>IN-NETWORK BENEFITS</p> <ul style="list-style-type: none"> Out-of-State <p>OUT-OF-NETWORK BENEFITS</p> <ul style="list-style-type: none"> All Areas 	<p>Outpatient self-management training and educational services covered at 100% of the discounted network rate when participating in an approved disease-state management program for diabetes, oncology, congestive heart failure, or asthma. Toll-free NurseCall 24 information service line available 24 hours per day, 7 days per week to answer any health-related questions and to assist Plan participants in determining the most appropriate level of care when medical attention is requested, including emergency room referrals. A self-care Guide, health brochures, and telephone access to health library recordings are available by request from NurseCall 24. Other publications covering a full range of health topics are mailed to the member. See Preventive (Wellness) Care for coverage of office visits and associated lab work and tests. Visit the MRN/Georgia 1st Web site at www.healthygeorgia.com for wellness information.</p> <hr/> <p>Same as above except: Outpatient self-management training and educational services covered at 80% of the discounted network rate when participating in an approved disease state management program for diabetes, oncology, congestive heart failure, or asthma.</p> <hr/> <p>Toll-free NurseCall 24 information service line and educational materials available as discussed above. Other publications covering a full range of health topics are mailed to the member. No coverage for preventive care office visits and associated lab work and tests.</p>
<p>HIGH OPTION</p> <ul style="list-style-type: none"> All Areas 	<p>Outpatient self-management training and educational services covered at 100% of the discounted network rate when participating in an approved disease state management program for diabetes, oncology, congestive heart failure, or asthma. Toll-free NurseCall 24 information service line and educational materials available as discussed above. Other publications covering a full range of health topics are mailed to the member.</p>

Options/Service Area	Behavioral Health Care
<p>AETNA U.S. HEALTHCARE AETNA U.S. HEALTHCARE CCO</p> <ul style="list-style-type: none"> Atlanta 	<p>Inpatient hospital and physician services are covered at 80% for 60 days per covered person in a calendar year. Outpatient services are covered at 100% for three brief situational counseling visits with a participating mental health professional in a calendar year. Outpatient professional psychiatric services are covered at 50% for no more than 20 visits in a calendar year. Substance abuse treatment is limited to three episodes per lifetime.</p>
<p>BLUECHOICE BLUECHOICE CCO</p> <ul style="list-style-type: none"> Atlanta Augusta Macon Savannah 	<p>Inpatient hospital and physician services are covered at 80% for 60 days per person each calendar year. Outpatient services are covered at 100% for three brief situational counseling visits with a network mental health provider in a calendar year. Outpatient physician services are covered at 100%, subject to a \$25 copayment per visit for no more than twenty 50-minute visits in a calendar year. Substance abuse treatment is limited to three episodes per lifetime.</p>
<p>KAISER PERMANENTE KAISER PERMANENTE CCO</p> <ul style="list-style-type: none"> Atlanta 	<p>Inpatient hospital and physician services are covered at 80% for 60 days per person and 50% thereafter in a calendar year. Outpatient services are covered at 100% for three brief situational counseling visits received from a Kaiser Permanente counselor per person in a calendar year. Outpatient professional psychiatric services are covered at 50%. Substance abuse treatment is limited to three episodes per lifetime.</p>

Options/Service Area	Home Health Care/Skilled Nursing Facilities
<p>AETNA U.S. HEALTHCARE AETNA U.S. HEALTHCARE CCO</p> <ul style="list-style-type: none"> Atlanta 	<p>Home health care and skilled nursing facility care covered at 100%, including physician and nursing services, diagnostic tests, medical supplies, physical and occupational therapy, and home health aids, when authorized by your participating Primary Care Physician and Aetna U.S. Healthcare’s Home Care Department.</p>
<p>BLUECHOICE BLUECHOICE CCO</p> <ul style="list-style-type: none"> Atlanta Augusta Macon Savannah 	<p>RN or LPN visits covered in full for up to 120 visits per calendar year when authorized by your Primary Care Physician. Skilled nursing facilities covered in full for 45 days (lifetime maximum), when medically necessary and authorized by a BlueChoice physician.</p>
<p>KAISER PERMANENTE KAISER PERMANENTE CCO</p> <ul style="list-style-type: none"> Atlanta 	<p>Part-time RN or LPN services covered in full when medically necessary. Skilled-nursing facilities covered in full for 45 days (lifetime maximum) when medically necessary. All services for home health care and skilled nursing must be approved by the Medical Group Chief of Quality Resource Management or Chief of Network Services, or their designee.</p>

Options/Service Area	Home Health Care/Skilled Nursing Facilities (continued)
<p>STANDARD PPO PPO CHOICE</p> <p>IN-NETWORK BENEFITS</p> <ul style="list-style-type: none"> Georgia 	<p>Two hours of home care per day by RN or LPN, if medically necessary and ordered by a physician, covered at 90% of network rate after the general deductible has been met, up to a maximum of \$7,500 per person per Plan Year. Annual maximum is combined with in-network/out-of-state and out-of-network benefit. Home health care charges are not applied to the stop-loss limit. If the MCP recommends home care in place of hospital care, additional benefits may be approved. No coverage for skilled nursing facilities. Hospice care covered at 100% when approved by the MCP, subject to the lifetime benefit maximum approved by Medicare.</p>
<p>IN-NETWORK BENEFITS</p> <ul style="list-style-type: none"> Out-of-State 	<p>Same as above except: Two hours of home care per day by RN or LPN, if medically necessary and ordered by a physician, covered at 80% of network rate after the general deductible has been met, up to a maximum of \$7,500 per person per Plan Year.</p>
<p>OUT-OF-NETWORK BENEFITS</p> <ul style="list-style-type: none"> All Areas 	<p>Two hours of home care per day by RN or LPN, if medically necessary and ordered by a physician, covered at 60% of OON rate after the general deductible has been met, up to a maximum of \$7,500 per person per Plan Year. Home health care charges are not applied to the stop-loss limit. If the MCP recommends home care in place of hospital care, additional benefits may be approved. No coverage for skilled nursing facilities. Hospice care covered at 60% when approved by the MCP, subject to the lifetime benefit maximum approved by Medicare.</p>
<p>HIGH OPTION</p> <ul style="list-style-type: none"> All Areas 	<p>Two hours of home care per day by RN or LPN, if medically necessary and ordered by a physician; covered at 90% of H/O rate after the general deductible has been met, up to a maximum of \$7,500 per person per Plan Year. Annual maximum is combined with in-network benefits. Home health care charges are not applied to the stop-loss limit. If the MCP recommends home care in place of hospital care, services are covered at 100%. No coverage for skilled nursing facilities. Hospice care covered at 100% when approved by the MCP, subject to the lifetime benefit maximum approved by Medicare.</p>

Options/Service Area	Outpatient Physical Therapy
AETNA U.S. HEALTHCARE AETNA U.S. HEALTHCARE CCO <ul style="list-style-type: none"> Atlanta 	\$20 copayment per visit for short-term treatment (60 consecutive days, per condition, per calendar year).
BLUECHOICE BLUECHOICE CCO <ul style="list-style-type: none"> Atlanta Augusta Macon Savannah 	\$15 per visit for up to 40 visits per calendar year when authorized by your Primary Care Physician.
KAISER PERMANENTE KAISER PERMANENTE CCO <ul style="list-style-type: none"> Atlanta 	\$15 copayment per visit for short-term treatment (60 consecutive days per condition), and \$15 copayment per visit for cardiac rehabilitation (up to 12 weeks or 36 visits) when authorized by the Medical Group Chief of Quality Resource Management or Chief of Network Services, or their designee.
STANDARD PPO PPO CHOICE IN-NETWORK BENEFITS <ul style="list-style-type: none"> Georgia IN-NETWORK BENEFITS <ul style="list-style-type: none"> Out-of-State OUT-OF-NETWORK BENEFITS <ul style="list-style-type: none"> All Areas 	Up to 40 visits per Plan Year covered at 90% of network rate after general deductible is met. Visit limitation is combined with in-network/out-of-state benefit and/or out-of-network benefit. Same as above except: Up to 40 visits per Plan Year covered at 80% of network rate after general deductible is met. Up to 40 visits per Plan Year covered at 60% of OON rate after general deductible is met.
HIGH OPTION <ul style="list-style-type: none"> All Areas 	Up to 40 visits per Plan Year covered at 90% of H/O rate after general deductible is met.

Options/Service Area	Durable Medical Equipment
<p>AETNA U.S. HEALTHCARE AETNA U.S. HEALTHCARE CCO</p> <ul style="list-style-type: none"> Atlanta 	<p>Covered in full for certain durable medical equipment that is medically necessary and approved by your Aetna U.S. Healthcare participating Primary Care Physician.</p>
<p>BLUECHOICE BLUECHOICE CCO</p> <ul style="list-style-type: none"> Atlanta Augusta Macon Savannah 	<p>100% coverage when medically necessary and authorized by your Primary Care Physician.</p>
<p>KAISER PERMANENTE KAISER PERMANENTE CCO</p> <ul style="list-style-type: none"> Atlanta 	<p>Covered in full for equipment in accordance with Medicare guidelines when medically necessary and approved by the Medical Group Chief of Quality Resource Management or Chief of Network Services, or their designee.</p>
<p>STANDARD PPO PPO CHOICE</p> <p>IN-NETWORK BENEFITS</p> <ul style="list-style-type: none"> Georgia <p>IN-NETWORK BENEFITS</p> <ul style="list-style-type: none"> Out-of-State <p>OUT-OF-NETWORK BENEFITS</p> <ul style="list-style-type: none"> All Areas 	<p>Covered at 90% of network rate after the general deductible is met, for rental or purchase of certain basic durable medical equipment from a participating provider that is medically necessary and approved by a participating physician and the SHBP. Examples of durable medical equipment include canes, crutches, wheelchairs, etc. (see Glossary). Balance billing does not apply when using a participating provider.</p> <p>Same as above except: Covered at 80% of network rate after the general deductible is met, for rental or purchase of certain basic durable medical equipment from a participating provider that is medically necessary and approved by a participating physician and the SHBP.</p> <p>Covered at 60% of OON rate after the general deductible is met, for rental or purchase of certain basic durable medical equipment that is medically necessary and is approved by the SHBP. Balance billing may apply.</p>
<p>HIGH OPTION</p> <ul style="list-style-type: none"> All Areas 	<p>Covered at 90% of H/O rate after the general deductible is met, for rental or purchase of certain basic durable medical equipment that is medically necessary and approved by a participating physician and the SHBP. Balance billing may apply.</p>

Options/Service Area	Dental Care
<p>AETNA U.S. HEALTHCARE AETNA U.S. HEALTHCARE CCO</p> <ul style="list-style-type: none"> Atlanta 	<p>Dental procedures for surgery or treatment of the teeth and gums for tumors and cysts, fractures of the jaw, and repair of accidental injury to sound natural teeth is covered at 100%. Extraction of bony impacted wisdom teeth is covered. Temporomandibular joint dysfunction (TMJ) is covered with Primary Care Physician referral to specialist for the surgical or non-surgical treatment of TMJ, including oral appliances. Periodontal surgery is not covered.</p>
<p>BLUECHOICE BLUECHOICE CCO</p> <ul style="list-style-type: none"> Atlanta Augusta Macon Savannah 	<p>100% coverage for oral surgery and dental services for accidental injury to sound teeth. Extraction of impacted wisdom teeth and TMJ are included as covered medical services. Periodontal surgery is not covered.</p>
<p>KAISER PERMANENTE KAISER PERMANENTE CCO</p> <ul style="list-style-type: none"> Atlanta 	<p>Dental care for accidental injury to sound natural teeth is covered at 80% of charges for dental surgery and appliances for mouth, jaw, and tooth restoration performed within 365 days after the injury. Non-surgical dental treatment and appliances for TMJ are covered at 50%. Extraction of impacted wisdom teeth is not covered. Periodontal surgery is not covered.</p>
<p>STANDARD PPO PPO CHOICE</p> <p>IN-NETWORK BENEFITS</p> <ul style="list-style-type: none"> Georgia <p>IN-NETWORK BENEFITS</p> <ul style="list-style-type: none"> Out-of-State <p>OUT-OF-NETWORK BENEFITS</p> <ul style="list-style-type: none"> All Areas 	<p>Benefits are provided for dental work done only in connection with the prompt repair of damage to natural tissue or natural teeth and for specified surgical procedures. Payment for covered dental services is 90% of network rate after the general deductible is met. Extraction of impacted teeth is not covered. Lifetime benefit limit for treatment of TMJ is \$1,100. Lifetime limit is combined total for PPO and High Option. Hospital charges for these procedures are covered as are other hospital costs; see Hospital Services.</p> <p>Same as above except: Payment for covered dental services is 80% of network rate after the general deductible is met.</p> <p>Benefits are provided for dental work done in connection with the prompt repair of damage to natural tissue or natural teeth and for specified surgical procedures. Payment for covered dental services is 60% of OON rate after the general deductible is met. Extraction of impacted teeth is not covered. Lifetime benefit limit for treatment of TMJ is \$1,100. Lifetime limit is combined total for PPO and High Option. Hospital charges for these procedures are covered as are other hospital costs; see Hospital Services.</p>
<p>HIGH OPTION</p> <ul style="list-style-type: none"> All Areas 	<p>Benefits are provided for dental work done only in connection with the prompt repair of damage to natural tissue or natural teeth and for specified surgical procedures. After meeting the general deductible, payment for covered dental services is 90% of H/O rate. Extraction of impacted teeth is not covered. Lifetime benefit limit for treatment of TMJ is \$1,100. Lifetime limit is combined total for PPO and High Option. Hospital charges for these procedures are covered as are other hospital costs; see Hospital Services.</p>

Options/Service Area	Maximum Benefits
AETNA U.S. HEALTHCARE AETNA U.S. HEALTHCARE CCO <ul style="list-style-type: none"> Atlanta 	No maximum.
BLUECHOICE BLUECHOICE CCO <ul style="list-style-type: none"> Atlanta Augusta Macon Savannah 	No maximum.
KAISER PERMANENTE KAISER PERMANENTE CCO <ul style="list-style-type: none"> Atlanta 	No maximum.
STANDARD PPO PPO CHOICE IN-NETWORK BENEFITS <ul style="list-style-type: none"> Georgia IN-NETWORK BENEFITS <ul style="list-style-type: none"> Out-of-State OUT-OF-NETWORK BENEFITS <ul style="list-style-type: none"> All Areas 	<p>\$2,000,000 per person for lifetime. When an employee or an eligible dependent enrolls (except for a dependent child being enrolled at birth), benefits payable for treatment of a preexisting condition are limited to \$1,000 until the patient has been free of treatment for six months or has been insured under the SHBP for a year; waiting period may be reduced based on federal legislation. Separate lifetime benefit maximums include the following: \$1,100 for the treatment of TMJ; three episodes of substance abuse treatment; \$500,000 combined limit for organ and tissue transplants; and \$500,000 for home hyperalimentation. Lifetime benefit maximums are combined with High Option.</p> <p>Benefits paid to out-of-network providers are applied toward in-network maximums described above. There are no separate out-of-network limits for preexisting conditions or lifetime benefit maximums.</p>
HIGH OPTION <ul style="list-style-type: none"> All Areas 	Same as Standard PPO option. Lifetime benefit maximums are combined with PPO maximums.

Options/Service Area	Major Exclusions
<p>AETNA U.S. HEALTHCARE AETNA U.S. HEALTHCARE CCO</p> <ul style="list-style-type: none"> Atlanta 	<p>Services not provided or authorized or referred by your Aetna U.S. Healthcare Primary Care Physician (except in an emergency); reversal of sterilization procedures; periodontal surgery and non-prescription medications. Advanced reproductive techniques, including in vitro fertilization (IVF), gamete interfallopian transfer (GIFT), zygote interfallopian transfer (ZIFT), embryo transfers and related procedures, and injectable medications for infertility are not covered. This is a summary of exclusions and not a complete list.</p>
<p>BLUECHOICE BLUECHOICE CCO</p> <ul style="list-style-type: none"> Atlanta Augusta Macon Savannah 	<p>Services not provided or authorized by your Primary Care Physician (except life-threatening emergencies), routine vision checkups, dental care (except the removal of impacted wisdom teeth and the treatment of TMJ), periodontal surgery, in vitro fertilization, long-term physical therapy, learning disabilities, reversal of voluntary sterilization, custodial care, and non-prescription items. This is a summary of exclusions and not a complete list.</p>
<p>KAISER PERMANENTE KAISER PERMANENTE CCO</p> <ul style="list-style-type: none"> Atlanta 	<p>Services not provided or authorized by a Kaiser Permanente physician except in emergencies: advanced reproductive techniques such as IVF, long-term physical therapy, custodial care, periodontal surgery, extraction of impacted wisdom teeth, non-prescription items, prescription drugs not listed in the Kaiser Permanente Drug Formulary (an exception process is available), and disposable supplies. This is a summary of exclusions and not a complete list.</p>
<p>STANDARD PPO PPO CHOICE</p> <p>IN-NETWORK BENEFITS</p> <ul style="list-style-type: none"> Georgia <p>IN-NETWORK BENEFITS</p> <ul style="list-style-type: none"> Out-of-State <p>OUT-OF-NETWORK BENEFITS</p> <ul style="list-style-type: none"> All Areas 	<p>Custodial care, dental services (except as noted); routine vision care (see Vision Screenings), in vitro fertilization, reversal of sterilization procedures, infertility drugs, non-prescription items, and cosmetic surgery. For limitations regarding preexisting conditions, see Maximum Benefits. This is a summary of exclusions and not a complete list.</p> <p>Preventive care, dental services (except as noted); routine vision care (See Vision Screening), well-baby and well-child care, custodial care, in vitro fertilization, reversal of sterilization procedures, infertility drugs, and non-prescription items, cosmetic surgery. For limitations regarding preexisting conditions, see Maximum Benefits. This is a summary of exclusions and not a complete list.</p>
<p>HIGH OPTION</p> <ul style="list-style-type: none"> All Areas 	<p>Custodial care, dental services (except as noted); routine vision care (see Vision Screenings), in vitro fertilization, reversal of sterilization procedures, infertility drugs, and non-prescription items, cosmetic surgery. For limitations regarding preexisting conditions, see Maximum Benefits. This is a summary of exclusions and not a complete list.</p>

Options/Service Area	Vision Screenings (for Corrective Lenses) and Eyewear
<p>AETNA U.S. HEALTHCARE AETNA U.S. HEALTHCARE CCO</p> <ul style="list-style-type: none"> Atlanta 	<p>Vision screening exams at participating specialists, ophthalmologists, or optometrists are covered in full after \$20 copayment. Aetna also offers a discount program at optical centers nationwide. Please call (800) 793-8616 to access the automated locator or to select DocFind on the Aetna U.S. Healthcare Web site at www.aetnaushc.com. You may be eligible for a \$70 reimbursement for prescription eyewear, either contact lenses or frames and lenses, once every 24 months. Discounts effective January 1, 2001, through December 31, 2001. The discount program described is a discount-only program, which may be in addition to any plan benefits.</p>
<p>BLUECHOICE BLUECHOICE CCO</p> <ul style="list-style-type: none"> Atlanta Augusta Macon Savannah 	<p>Members are eligible for a value-added vision discount program at participating LensCrafters stores in Georgia or independent BlueChoice vision optometrists. This is not a vision benefit but instead a discount program where you can save on eye exams and a broad selection of eyewear. Discounts at LensCrafters include: three-tiered selection of eyeglasses through preset, discounted package prices; 30% off the regular retail price of any non-BlueChoice Vision package eyeglasses; contact lenses at low fixed prices; eye exams at low fixed prices by independent doctors of optometry located at LensCrafters; 25% off the regular retail price on non-prescription sunglasses. Discounts at independent BlueChoice vision optometrists: 30% off the regular retail price of any eyeglasses; contact lenses at low fixed prices; eye exams at low fixed prices; 25% off the regular retail price on non-prescription sunglasses. For a list of providers or to learn more about the program, please call (800) 377-6436 or visit the BlueCross BlueShield Web site at www.bcbsga.com.</p>
<p>KAISER PERMANENTE KAISER PERMANENTE CCO</p> <ul style="list-style-type: none"> Atlanta 	<p>\$15 copayment per visit for eye exams for corrective lenses (and screenings for eye diseases) from participating providers designated by Kaiser Permanente. Additionally, you receive a 25% discount off of eyeglasses, a 15% discount off of regular contact lenses, and a 5% discount off of disposable contact lenses when purchased from participating providers designated by Kaiser Permanente.</p>

Options/Service Area	Vision Screenings (for Corrective Lenses) and Eyewear
<p>STANDARD PPO PPO CHOICE</p> <p>IN-NETWORK BENEFITS (participating vision providers)</p>	<p>Members are eligible for a value-added vision discount program at participating LensCrafters stores in Georgia or independent BlueChoice vision optometrists. This is not a vision benefit but instead a discount program where you can save on eye exams and a broad selection of eyewear. Discounts at LensCrafters include: three-tiered selection of eyeglasses through preset, discounted package prices; 30% off the regular retail price of any non-BlueChoice Vision package eyeglasses; contact lenses at low fixed prices; eye exams at low fixed prices by independent doctors of optometry located at LensCrafters; 25% off the regular retail price on non-prescription sunglasses. Discounts at independent BlueChoice vision optometrists: 30% off the regular retail price of any eyeglasses; contact lenses at low fixed prices; eye exams at low fixed prices; 25% off the regular retail price on non-prescription sunglasses. For a list of providers or to learn more about the program, please call (800) 377-6436 or visit the BlueCross BlueShield Web site at www.bcbsga.com.</p>
<p>OUT-OF-NETWORK BENEFITS</p> <ul style="list-style-type: none"> All Areas 	<p>Not applicable</p>
<p>HIGH OPTION</p> <ul style="list-style-type: none"> All Areas 	<p>Same as Standard PPO Option</p>

Conditions Under Which You Can Make Changes



Retiree Option Change Period

- You can change your Health Plan option annually during the Retiree Option Change Period. You may change to any SHBP option for which you are eligible. But you must file paperwork, or change your option online, before the Retiree Option Change Period deadline—May 15, 2001.
- The Retiree Option Change Period is not an “Open Enrollment.” New dependents may not be added unless you have a qualifying event as discussed in your Plan documents.
- Once you’ve chosen an option and registered your decision, either online, or by filing the proper form(s) with the SHBP, you can’t just *drop out*. Your coverage selection constitutes a one-year contract. You must remain in your choice until the next Retiree Option Change Period, unless a qualifying event permits a change, as described here, and in your SHBP booklet and subsequent UPDATERS.

Qualifying Events

- Qualifying events include marriage, divorce, a new dependent, your spouse loses coverage through his or her employment, death, attainment of Medicare eligibility, or moving out of an HMO service area. If you need to change your election because of a change in family status, your new election must be filed with the SHBP within 31 days of the qualifying event. (*Refer to the SHBP booklet titled State Health Benefit Plan, November 1, 1995 and subsequent UPDATERS, for a complete description of qualifying events.*)

Service Areas for State Health Benefit Plan Options



Standard PPO and PPO Choice Options

Effective July 1, 2001, the PPO option will have a national network available. All members will be eligible for PPO Option coverage from a PPO provider participating in the national Beech Street network outside Georgia. Please consider the following points if you require care while traveling or if you or a dependent lives outside the state or you wish to receive care from a national PPO provider outside of Georgia:

- Benefit coverage under the PPO options generally will be at one of three levels depending on where you receive care. Coverage will be at the 90% level for in-network PPO services received in-state and in the border communities of the Chattanooga, Tennessee area, including Bradley County; and Phenix City, Alabama; 80% for in-network PPO services received out-of-state; and 60% for out-of-network services received in any area.
- Members are responsible for precertifying inpatient stays and specified outpatient tests and procedures, whether or not the provider participates in the national network.
- The national PPO network used by the Health Plan does not include any providers in Georgia, mental health/substance abuse providers, or transplant providers. Georgia providers participate in the PPO through the MRN/Georgia 1st joint venture. A 90% level of benefit coverage is available for these providers.
- If you require emergency care or acute care, the Plan will pay the higher in-network level of benefit coverage (90%), regardless of where you receive care or treatment. However, if you use a participating PPO provider, you are not subject to balance billing and could save money.

Additionally, if you use a participating provider you do not have to pay at the time you receive services since benefits are payable directly to the provider. If you or anyone with you is able, call NurseCall 24 at 1-800-524-7130 (24 hours per day, 7 days per week) for information on the nearest participating providers.

- If you are planning to travel outside of Georgia or you have a dependent living outside of Georgia, go to www.healthygeorgia.com to find the locations of participating providers in selected areas across the country. (The site includes a link to Beech Street network providers.) You may also contact member services to request a printed directory of Beech Street providers for the area(s) of your choice or to receive provider information over the phone. (*See the inside front cover of this Guide for the Member Services number.*)
- Note: There is no *international* network of participating providers in the PPO Options.
- When possible, check to see if the provider is participating in the national PPO network or, if you are seeking services inside Georgia, see if the provider is in the MRN/Georgia 1st network. Be aware that it is possible that a participating hospital does not have participating hospital-based physicians, in which case you may be balance billed by those physicians.
- If you are a current PPO Choice Option member or you are considering PPO Choice, please note that you may only nominate providers licensed and located in Georgia—even if you live out-of-state.
- Effective July 1, 2001, the Standard PPO will no longer be restricted to members living in selected zip code areas. All members eligible for SHBP coverage may select the Standard PPO or PPO Choice Option.

The Georgia service area used to determine the in-network/Georgia level of benefit coverage will include zip codes for all of Georgia, and the border communities of the Chattanooga, Tennessee area, including Bradley County; and Phenix City, Alabama. If you receive services from a provider that is not located in one of the zip codes listed below, then you would not

be able to receive the in-network/Georgia level of benefits coverage, unless you require emergency services. Also remember that you must use an MRN/Georgia 1st provider located in one of the listed zip codes in order to receive the 90% level of benefit coverage.

Georgia Service Area			
Georgia	Alabama	Tennessee	
	Phenix City area	Cleveland area	Chattanooga area
All Counties	Russell County	Bradley County	Hamilton County
All Zip Codes	36067 36069 36867 36869	37311 37312 37320 37323	30720 37402 31901 37403 37311 37404 37315 37405 37321 37406 37327 37407 37331 37410 37341 37411 37343 37412 37363 37415 37377 37416 37379 37421 37380 37499 37401 37620

High Option

The High Option is available to anyone eligible for SHBP coverage, regardless of residence.

HMO Options (including Consumer Choice Options)

HMO Option service areas are composed of approved counties. You must live in the HMO’s approved service area to be eligible for coverage in the HMO option. (See pages 58-61 of this Guide for residence requirements.)

Medicare+Choice HMO Service Areas



If your county of residence is marked “yes” and you are enrolled in Medicare, you are eligible to join the M+C HMO. If you don’t live in an area where the Medicare+Choice HMO is available, look at the charts on pages 59–61 to see if you live in the service

areas for the regular HMOs. If you do not live in an M+C service area you may be eligible for coverage under one of the regular HMOs.

Residence Requirements

Atlanta Medicare+Choice HMO Service Area	
Your County of Residence	Kaiser Permanente
Cherokee	Yes
Clayton	Yes
Cobb	Yes
Coweta	Yes
DeKalb	Yes
Douglas	Yes
Fayette	Yes
Forsyth	Yes
Fulton	Yes
Gwinnett	Yes
Henry	Yes
Paulding	(Only zip codes 30127, 30134, and 30141)
Rockdale	Yes

Note: Aetna M+C and BlueChoice M+C are no longer available.

Important Note:

If you are a BlueChoice Medicare+Choice member, and you do not indicate another choice-in writing, or online during the Retiree Option Change Period, the Plan will automatically place you in the Standard PPO option. If you do not want coverage under the PPO, you must indicate your benefit changes online (at www.statehealth.org) or on the appropriate form before the May 15, 2001 deadline.

Regular HMO Service Areas



HMO option service areas are composed of approved counties. Take a look at the charts below to see if your county of residence is marked “yes” under the name of the HMO. If “yes,” you are eligible to join.

Note: You must live in the HMO’s approved service area to be eligible for coverage under that option.

Residence Requirements

Atlanta HMO Service Area			
Your County of Residence	Aetna US Healthcare Aetna US Healthcare CCO	BlueChoice BlueChoice CCO	Kaiser Permanente Kaiser Permanente CCO
Barrow	Yes	Yes	Yes
Bartow	Yes	Yes	Yes
Butts	Yes	Yes	Yes
Carroll	Not Available	Closed to new members	Not Available
Cherokee	Yes	Yes	Yes
Clarke	Yes	Yes	Not Available
Clayton	Yes	Yes	Yes
Cobb	Yes	Yes	Yes
Coweta	Yes	Yes	Yes
Dawson	Not Available	Yes	Not Available
DeKalb	Yes	Yes	Yes
Douglas	Yes	Yes	Yes
Fayette	Yes	Yes	Yes
Forsyth	Yes	Yes	Yes
Fulton	Yes	Yes	Yes
Gwinnett	Yes	Yes	Yes
Hall	Yes	Yes	Closed to new members
Henry	Yes	Yes	Yes
Jackson	Yes	Yes	Not Available
Lumpkin	Not Available	Yes	Not Available

Atlanta HMO Service Area (Continued)

Your County of Residence	Aetna US Healthcare Aetna US Healthcare CCO	BlueChoice BlueChoice CCO	Kaiser Permanente Kaiser Permanente CCO
Madison	Not Available	Yes	Not Available
Newton	Yes	Yes	Yes
Oconee	Closed to new members	Yes	Not Available
Oglethorpe	Not Available	Closed to new members	Not Available
Paulding	Yes	Yes	Yes
Pickens	Yes	Not Available	Not Available
Rockdale	Yes	Yes	Yes
Spalding	Yes	Yes	Yes
Walton	Yes	Yes	Yes

Augusta HMO Service Area

Your County of Residence	Aetna US Healthcare Aetna US Healthcare CCO	BlueChoice BlueChoice CCO	Kaiser Permanente Kaiser Permanente CCO
Burke	Not Available	Yes	Not Available
Columbia		Yes	
Jefferson		Yes	
Lincoln		Yes	
McDuffie		Yes	
Richmond		Yes	

Macon HMO Service Area

Your County of Residence	Aetna US Healthcare Aetna US Healthcare CCO	BlueChoice BlueChoice CCO	Kaiser Permanente Kaiser Permanente CCO
Baldwin	Not Available	Closed to New Members	Not Available
Bibb		Yes	
Bleckley		Yes	
Houston		Yes	
Jones		Yes	
Laurens		Closed to New Members	
Peach		Yes	
Pulaski		Yes	
Twiggs		Yes	
Wilkinson		Yes	

Savannah HMO Service Area

Your County of Residence	Aetna US Healthcare Aetna US Healthcare CCO	BlueChoice BlueChoice CCO	Kaiser Permanente Kaiser Permanente CCO
Bryan	Not Available	Yes	Not Available
Bulloch		Yes	
Chatham		Yes	
Effingham		Yes	
Liberty		Yes	

Results of Customer Satisfaction Surveys



The following section compares your satisfaction level among the HMO options offered under the SHBP, by various categories. All the responses are from SHBP members, including state employees, teachers, school service employees, and retirees. The respective Plan option administrator sponsored surveys and independent research firms generally compiled results.

(The Standard PPO option satisfaction ratings are not available for this year's comparison since one full Plan Year had not elapsed when the data were compiled. High Option ratings are not available since it is an indemnity-type plan without managed provider networks.)

Service Areas

Aetna US Healthcare		BlueChoice		Kaiser Permanente	
Atlanta only		Atlanta		Atlanta only	
		Augusta			
		Macon			
		Savannah			

Quality of Care—Are you satisfied with the overall quality of care and services received from your health care providers?

Aetna US Healthcare		BlueChoice		Kaiser Permanente	
Satisfied	Dissatisfied	Satisfied	Dissatisfied	Satisfied	Dissatisfied
88%	5%	89%	3%	89%	5%

Provider Courtesy—Are you satisfied with the friendliness and courtesy shown to you by providers?

Aetna US Healthcare		BlueChoice		Kaiser Permanente	
Satisfied	Dissatisfied	Satisfied	Dissatisfied	Satisfied	Dissatisfied
91%	3%	93%	2%	92%	2%

Customer Service Courtesy—Are you satisfied with the friendliness and courtesy shown to you by customer service representatives?

Aetna US Healthcare		BlueChoice		Kaiser Permanente	
Satisfied	Dissatisfied	Satisfied	Dissatisfied	Satisfied	Dissatisfied
84%	7%	88%	5%	88%	6%

Access to Care—Are you satisfied with the geographic accessibility of the physician’s office?

Aetna US Healthcare		BlueChoice		Kaiser Permanente	
Satisfied	Dissatisfied	Satisfied	Dissatisfied	Satisfied	Dissatisfied
88%	5%	90%	4%	87%	6%

Waiting Times—Are you satisfied with the length of time that you have to wait between making an appointment for routine care and the day of your visit?

Aetna US Healthcare		BlueChoice		Kaiser Permanente	
Satisfied	Dissatisfied	Satisfied	Dissatisfied	Satisfied	Dissatisfied
75%	19%	79%	12%	76%	17%

Customer Service Problem Solving—Are you satisfied with the ability of customer service representatives to provide specific directions or answers to any claim issues or problems you may have?

Aetna US Healthcare		BlueChoice		Kaiser Permanente	
Satisfied	Dissatisfied	Satisfied	Dissatisfied	Satisfied	Dissatisfied
67%	22%	72%	17%	65%	18%

Customer Service Performance—Are you satisfied with the overall performance of customer service representatives?

Aetna US Healthcare		BlueChoice		Kaiser Permanente	
Satisfied	Dissatisfied	Satisfied	Dissatisfied	Satisfied	Dissatisfied
71%	15%	77%	9%	78%	10%

Overall Satisfaction—All things considered, are you satisfied with your current Health Plan?

Aetna US Healthcare		BlueChoice		Kaiser Permanente	
Satisfied	Dissatisfied	Satisfied	Dissatisfied	Satisfied	Dissatisfied
81%	14%	84%	12%	90%	6%

Note: You will notice that the total percentage of responses does not add up to 100%. We only included responses that clearly indicated, one way or the other, the satisfaction level you expressed about a particular option. (We accomplished this by leaving out “middle-of-the-road” responses.) For your convenience, we condensed responses into two categories—“satisfied” or “dissatisfied.”

If You Need More Information



Plan to Attend a Meeting Near You

State Health Benefit Plan representatives will hold meetings throughout Georgia to provide additional information and details about the material outlined here. Refer to the separate list included in this package for the location, date, and time of a meeting in your area.

The Retiree Help Line

Call the Retiree Help Line if you need immediate answers to questions about changing your coverage option. You can contact the Retiree Help Line toll-free at **(800) 230-2291**. **Help Line representatives are available to take your calls between 8:00 a.m. and 6:00 p.m. Eastern Time, Monday through Friday.**

Note: This special Retiree Help Line is available only during the 2001 – 2002 Retiree Option Change Period—April 16 through May 15, 2001. Afterwards, please call the appropriate Members Services numbers.

Glossary



Acute Care

Care provided when such services are medically necessary and immediately required as a result of a sudden onset of illness or injury.

Allowed Amounts

A dollar figure the Plan uses to calculate benefits payable. For example, in the Standard PPO Option, the allowed amount is based in part on the network rate. **Plan members using out-of-network providers (PPO option) or non-participating providers (High Option) are responsible for paying any amount charged over the allowed amount.** PPO members using network providers are charged only up to the allowed amount and are not subject to an additional payment for that service.

Ancillary Provider

Suppliers of covered medical services and procedures, including but not limited to ambulance services, durable medical equipment suppliers, chiropractors, home health and hospice care services, and physical therapists.

Balance Billing

A dollar amount charged by a provider that is over the Plan's allowed amount for the care or treatment received. Amounts balance billed are the member's responsibility and do not apply to

the Plan's stop-loss limits or deductibles. PPO providers do not bill for amounts over the allowed amounts, so members will not be subject to balance billing when using a network PPO provider. However, PPO members are subject to balance billing when using an out-of-network provider. High Option members may be balance billed by physicians who do not participate in the Participating Physicians Program (PPP) and by hospitals that do not have a direct contract with the state.

Behavioral Health Services (BHS)

The BHS program is a part of the PPO and High Options. It is a managed care program for mental health and substance abuse benefits. The program is designed to provide wide access to necessary care while balancing choice of provider, enhanced benefits within the network, and overall cost effectiveness. In order to receive full benefits, members must contact BHS prior to receiving behavioral health services.

Beneficiary

A beneficiary is someone who is eligible to receive benefits. For example, Medicare beneficiaries are entitled to benefits offered by the Medicare program.

Brand Name Drug

A drug that is advertised and sold using a trade name that is protected by patents so that it can be produced only by one pharmaceutical manufacturer for a predetermined number of years.

CCO

Consumer Choice Option.

CCU

Coronary care unit.

Coinsurance

A percentage of the provider's charge or the Plan's allowed amount that must be paid by the member for covered benefits and services, generally 10% to 40%. Coinsurance is applied toward deductibles and stop-loss limits.

Copayment

A fixed dollar amount that must be paid by the member for a particular service or item at the time it is received; for example, \$10 or \$20 for office visits. Copayments do not apply toward deductibles or stop-loss limits.

Custodial Care

Assistance with the routine activities of daily living (bathing, dressing, eating, etc.), or running errands for the patient. Generally, care is considered custodial if it can be provided by an untrained adult with little or no supervision.

Deductible

A fixed dollar amount that must be paid out-of-pocket by the patient before any benefit is payable by the patient's health care plan. This is paid each Plan Year and, in some cases, paid per hospital admission, depending on your coverage option.

Disposable Supplies

Medical supplies of a non-durable nature that are not intended for repeated use; that are used primarily for a medical purpose; and that are appropriate for use in a patient's home—for example, diabetic supplies (test strips, syringes, lancets, etc.) and ostomy supplies.

Durable Medical Equipment

Medical supplies of a non-disposable nature that can withstand repeated use; that are used primarily for a medical purpose; that generally are not useful to a healthy person; and that are appropriate for use in a patient's home—for example, crutches or a wheelchair.

Emergency Care

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

Generic Drug

A drug for which the patent has expired, allowing other manufacturers to produce and distribute the product. Generics are essentially a chemical copy of their brand name equivalent. The color or shape may be different, but the active ingredients must be the same for both. Companies that produce generic equivalents are required to follow stringent FDA regulations for safety.

Health Care Financing Administration (HCFA)

HCFA is a government agency responsible for the overall administration of the Medicare program, including the review and approval of the Medicare+Choice health plan option.

Health Maintenance Organization (HMO)

An HMO is a network of health care providers that offers services at discounted rates. Under an HMO, a Primary Care Physician (PCP) coordinates your care and you must seek care within the network to receive benefits. If you receive care outside the HMO's network, you are responsible for 100% of your medical expenses, unless it is a life-threatening emergency.

High Option (H/O) Rate

The dollar amount used in determining an allowed amount in the High Option, which is determined by the SHBP and based in part on contracted rates.

Hospital-Based Physicians

Anesthesiologists, emergency room physicians, pathologists, and radiologists.

ICU

Intensive care unit.

Indemnity Plan

A health plan model allowing members freedom to select providers and to direct their own care. The High Option is an indemnity-type plan which includes a network of participating providers that may not balance bill members.

Institutional Charges

Expenses incurred in and billed by a hospital or ambulatory surgical center.

M+C

Medicare+Choice

Medical Certification Program (MCP)

The MCP is a part of the PPO and High Options. It is designed to help members and the Plan save money by preventing unnecessary care. To avoid a reduction in benefits, you must comply with the MCP requirements outlined in Plan documents.

Medicare

The federal health insurance program for Americans age 65 and older and some disabled people under age 65. Medicare has two parts: Part A for Hospital Insurance and Part B for Supplementary Medical Insurance.

Medicare Part A

When you become eligible, you automatically receive benefits from Medicare Part A. Part A provides hospital insurance and covers inpatient care, room and board, skilled nursing facilities, home health care, hospice and certain follow-up care after you leave the hospital. You do not pay a premium for Part A.

Medicare Part B

When you become eligible for Medicare, you also can enroll for coverage under Part B. Medicare Part B provides supplementary medical coverage and covers physician's fees, outpatient services, surgery, anesthesia, laboratory tests, X-rays, and many other services not covered by Part A. You pay a monthly premium to Medicare.

Network

A group of doctors, hospitals, and other providers that have contracted with a PPO, HMO, etc. to offer health care services at negotiated rates.

Network Provider

A doctor, hospital, ancillary provider, or treatment facility that has contracted to be part of a network. Network providers must meet certain quality standards and agree to negotiated fee arrangements and ongoing quality reviews.

Non-Preferred Brand Name Drug

A brand name drug that is not on the Plan's preferred drug list.

NurseCall 24

A toll-free medical information service offering advice from registered nurses. This information service line is available 24 hours a day, 7 days a week to answer health-related questions and to assist Plan participants in determining the most appropriate level of care when medical attention is requested.

OB/GYN

Obstetrician and gynecologist.

Out-of-Network Provider

A health care provider who is not a member of the PPO network is considered an out-of-network provider.

Out-of-Network (OON) Rate

The dollar amount used in determining an allowed amount in the Standard PPO Option and PPO Choice Option when non-participating providers are used, which is based in part on the network PPO rate.

Participating Physician Program (PPP)

(The PPP only applies to High Option members.) A contractual arrangement between the Plan's claims administrator, Blue Cross and Blue shield of Georgia Inc., and medical doctors who practice in Georgia. Each participating physician agrees to accept the Plan's allowed amount for his or her services and may not balance bill members. (Participating PPO providers also agree to accept the Plan's allowed amount and may not balance bill members.)

Plan Year

July 1 through June 30 of the following year.

Preferred Brand Name Drug

A brand name drug that is on the Plan's preferred drug list.

Preferred Drug List

A list of drugs that is created, reviewed, and continually updated by a team of physicians and pharmacists. The preferred drug list contains a wide range of generic and preferred brand name products that have been approved by the FDA. A medication becomes a preferred drug based first on safety and efficacy, then on cost effectiveness.

Preferred Provider Organization (PPO)

The PPO consists of a comprehensive network of doctors, ancillary providers, and hospitals that have agreed to offer quality medical care and services at discounted rates. You must use a participating network provider to receive the highest level of benefit coverage. If you choose a PPO, you have the flexibility to go out-of-network for your health care services and receive a reduced level of benefit coverage. With your out-of-network benefits, you can see any qualified provider of medical services. You pay a greater percentage of the charges for covered services if you go out-of-network and you are subject to balance billing for charges above the Plan's allowed amounts.

Primary Care Physician (PCP)

A doctor who has the primary responsibility for providing, arranging, and coordinating every aspect of a patient's health care. An HMO member must select a PCP. PPO members are not required to select a PCP. Generally, PCPs are either internists, general practitioners, family practitioners, pediatricians, or OB/GYNs.

Provider

Licensed medical doctors, hospitals, and other health care providers through whom the PPO, High Option, or HMO offers coverage.

Qualifying Events

Qualifying events are changes in family or employment status that may give you the right to change your benefit coverage at times other than the Retiree Option Change Period. Qualifying events can include marriage, divorce, a new dependent, your spouse's loss of coverage through employment, or death. If you need to change your election because of a change in family status, your new election must be filed with the SHBP within 31 days of the qualifying event. (Refer to the SHBP booklet titled State Health Benefit Plan, November 1, 1995, and subsequent UPDATER for a complete description of qualifying events.

RN/LPN

Registered Nurse/Licensed Practical Nurse.

SHBP

State Health Benefit Plan.

Self-Insured Benefit Plan

A program of medical care reimbursement in which an employer and its employees pay the costs of employee health care; no outside insurance company underwrites the risk or makes a profit. The High Option and PPO options are examples of self-insured benefit plans.

Service Area

A service area consists of approved counties or geographic areas in which in-network services are available.

Stop-Loss Limit

A maximum annual dollar amount that a Plan member would have to pay out-of-pocket for covered expenses. Once the stop-loss limit is reached, covered expenses for the remainder of the Plan Year are reimbursed at 100%. Stop-loss limits are available per person and per family.

TMJ

Temporomandibular Joint Dysfunction.