

Active Employee Decision Guide

for Plan
Year 2013



**Open Enrollment Period:
October 9 – November 9, 2012**

Additional Help/Contact Information

State Health Benefit Plan (SHBP):



Vendor	Member Services	Website
CIGNA HRA, HMO, HDHP 24 hours a day / 7 days a week	800-633-8519 TTY 711	www.mycigna.com/shbp
UnitedHealthcare HRA HMO, HDHP hours 8 a.m. – 8 p.m. local time zone; Monday – Friday, TTY 711	800-396-6515 877-246-4189	www.welcometouhc.com/shbp www.welcometouhc.com/shbp
SHBP Eligibility	800-610-1863	www.dch.georgia.gov/shbp
Additional Information	Member Services	Website
TRICARE Supplemental Plan hours 8:30 a.m. – 5 p.m. local time zone; Monday – Friday	866-637-9911	www.asicorporation.com/ga_shbp
PeachCare for Kids	877-427-3224	www.peachcare.org

Listed below are common health care acronyms that are used throughout this Decision Guide.

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|---|--|
| CDHP > Consumer-Driven Health Plan | MA (PPO) > Medicare Advantage Preferred Provider Organization |
| CMS > Centers for Medicare and Medicaid Services | OE > Open Enrollment |
| COB > Coordination of Benefits | PCF > Personalized Change Form |
| DCH > Georgia Department of Community Health | PCP > Primary Care Physician |
| FSA > Flexible Spending Account | ROCP > Retiree Option Change Period |
| HDHP > High Deductible Health Plan | SHBP > State Health Benefit Plan |
| HMO > Health Maintenance Organization | SPC > Specialist |
| HRA > Health Reimbursement Arrangement | SPD > Summary Plan Description |
| HSA > Health Savings Account | UHC > UnitedHealthcare |

Welcome to the Annual Open Enrollment (OE) Period

In this guide, you will find what's changing for the 2013 Plan Year, a brief explanation of each health insurance Option, a list of things to consider before making your decision and a benefit comparison chart.

See the Contents below to review the sections that apply to your situation.

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October 1, 2012

Dear State Health Benefit Plan (SHBP) Member:

This year's Open Enrollment holds opportunities for you to become more engaged with your health care and experience lower costs as a result. In keeping with Gov. Deal's Strategic Goals for the state, our SHBP increases consumer choices and personal responsibility in health care.

We want to thank those who completed our post-enrollment online survey last year. Many of the plan changes you'll see for Plan Year 2013 are the result of the comments you shared with us during our last Open Enrollment Period.

As you may know, last year Georgia's SHBP introduced voluntary Wellness Plan options. Many of you selected a Wellness Plan for Calendar Year 2012 and, as a result, Georgia currently has the largest wellness plan in the nation.

Again, the SHBP will offer a discount on premiums to those members who choose Wellness Plan options and agree to be actively engaged in wellness activities through the Wellness Promise. If you (and your covered spouse) fulfilled your Wellness Promise this year, you may once again enroll in a Wellness Plan for 2013.

The Standard Plan option, which does not require our members to engage in wellness activities, will have higher premiums and out-of-pocket costs than the Wellness Plan options. If you did not choose a Wellness Plan this year, you may do so next year for 2013. You will be asked to fulfill the Wellness Promise.

Once again, we're asking for your feedback and input. We have included a short online survey for you to complete following your 2013 Plan election.

We at the Georgia Department of Community Health are interested in you as state employees and will continue to do our best to meet the needs of our members. Please take the time to complete this year's survey to help us better serve you.

Sincerely,

A handwritten signature in cursive script that reads "David A. Cook".

David A. Cook
Commissioner

Welcome

to the Open Enrollment

October 9 - November 9, 2012 for January 1, 2013 - December 31, 2013
www.myshbp.ga.gov

In this guide, you will find a brief explanation of your responsibilities, each option, what's changing for the 2013 Plan Year and instructions on making your 2013 election.

Your Responsibilities as a SHBP Member

- Notify SHBP whenever you have a change in covered dependents within the time limits set by the SHBP
- Read and make sure you understand the materials provided to you
- Check your payroll deduction to verify the correct health deduction is made
- Update any change in address by making the correction online at www.myshbp.ga.gov during Open Enrollment or by completing and submitting a Miscellaneous Change Form posted at www.dch.georgia.gov/shbp
- Review all communications from the SHBP and take the required actions

During the Annual OE, You May:

- Change to any option for which you are eligible (Wellness Rules apply)
- Change your vendor (ex. Move from an Option administered by UnitedHealthcare to an Option administered by Cigna)
- Decrease/Increase tiers
- Drop covered dependents
- Discontinue SHBP coverage
- Enroll eligible dependents
- Enroll in coverage



Making Your Health Benefit Election for 2013

For technical assistance in making your 2013 Election online, call 800-610-1863

How to Make Your 2013 Election

Online—www.myshbp.ga.gov

- Dates and Hours: 4 a.m. October 9 - 4:30 p.m. November 9, 2012
- You must first register and set up a password before making your 2013 election
- Once registered you should:
 - Verify your address
 - Verify your coverage tier (you only, you & spouse, you & child(ren) or you & family)
 - Verify your dependents
 - Answer the Tobacco Surcharge question
 - Make sure you print your confirmation, write down the confirmation number, or save to your computer's hard drive

If you have a change:

- You may go online multiple times; however, the last Option selected and confirmed at the close of OE on November 9, 4:30 p.m. EST will be your Option for 2013 unless you experience a qualifying event that allows you to make a change
- Remember a confirmation number will be shown once your election has been processed. You should copy this number or print the confirmation page and keep it
- Do not wait until the last minute to make your election as web traffic and SHBP phone volumes are unusually heavy near the end of OE



IMPORTANT NOTE

The election made during the 2013 OE will be the coverage you have for the entire 2013 Plan Year unless you have a qualifying event that allows a change in your coverage. See Qualifying Events (QE) on page 29 for more information.

Important!

What Should I Do Before Making My Election?

- Evaluate your health care needs and compare the benefits under each option in relation to the premiums by going to www.mycigna.com or www.welcometomyuhc.com/shbp. These sites explain the differences in the plans and have cost estimator tools to help you determine which plan costs are less along with other valuable tools.
- Verify your provider(s) will be participating in the option you choose by going to the vendors' websites or calling the vendors.
- Check the distance you will have to drive to see your provider(s).
- Check the Preferred Drug Lists of each vendor to see if your prescriptions are covered and at what co-payment or co-insurance level.

Who Should I Contact if I Have Questions?

Benefit Questions:

- CIGNA for HRA, HMO or HDHP Options – **800-633-8519**
- UHC HRA – **800-396-6515**
- UHC HMO, HDHP – **877-246-4189**

Eligibility Questions:

- SHBP Call Center – **800-610-1863**
- SHBP E-Mail – shbpnoreply@dch.ga.gov

How Do I Decide Which Plan is Best for Me?

This can be a difficult decision but listed below are some things you may want to consider when making your decision.

- Are you able to afford your prescription drugs if you have to satisfy a deductible? If the answer is “No” then you should consider enrolling in the HRA or HMO Option.
- If you have very low or very high medical expenses, you may want to consider enrollment in the HRA or HDHP Plans. The premiums are lower than the HMO and the co-insurance applies to your out-of-pocket limit (except for prescription drugs under the HRA). With high medical expenses, the out-of-pocket limit is reached more quickly and expenses are then paid at 100% after the limit is reached.
- If you have very low expenses, the premium is lower in the HRA and you have 100% coverage for covered services until your HRA dollars are exhausted. Also, if you don't use all of your HRA dollars, they will roll to the next year provided you are in a HRA Option.
- If you take a number of prescriptions, compare costs for your prescriptions under each plan and you may want to consider using the Mail Order Program which should lower your prescription drug costs.

Department of Administration Services (DOAS) Flexible Benefits Program Participants

- Flexible Benefits Annual Enrollment. If you are eligible to make benefits elections under the Flexible Benefits Program, administered by the DOAS, please visit www.GaBreeze.ga.gov or call (877) 3GBreez (**877-342-7339**) to make your annual enrollment benefits elections. After confirming your elections online, print your confirmation showing your successful completion and keep it for your records. If you choose to call GaBreeze to make your benefit elections, you may request a confirmation be mailed to you. GaBreeze does not include your health election. You will make two confirmations: one for flexible benefits and a separate for confirmation for your health benefits.
- State Health Benefit Health Election. From the GaBreeze website, you have the ability to link to the SHBP for making your health election or may link directly to the SHBP at www.myshbp.ga.gov. After you complete your health election, print your confirmation and make sure it contains a confirmation number.

Board of Education or Agencies Not Participating in the DOAS Flexible Benefits Program

- Since you are not a participant of the State of Georgia Flexible Benefits Program, you will make your health election on www.myshbp.ga.gov. After you make your health election, print your confirmation and make sure it contains a confirmation number. This number confirms your health benefit election for the 2013 Plan Year. Contact your personnel/payroll office to obtain information regarding your other flexible benefits sponsored by your Board of Education.

IMPORTANT NOTE



Important!

- Dual coverage (more commonly referred to as State on State coverage) is when two members are eligible for coverage both as an employee and spouse under SHBP. For example: a member is eligible for SHBP coverage through his/her employment and his/her spouse is also eligible for SHBP coverage as an employee.
- If both members are eligible for coverage as employees, it may not be cost effective to cover each other as dependents. This is because regardless of the other coverage (SHBP or another group policy) you will still be responsible for co-payments, deductibles and non-covered or ineligible charges.
- Remember you only have 31 days before or after a qualifying event to add a dependent (90 days for a newborn).
- Remember to keep your address current. Only you or your authorized designee can change your address.

What if I Do Not Take Any Action?

If you do not take any action, you are choosing to otherwise remain in your current Option and tier, with the following exceptions:

- If you are currently enrolled in a Wellness Option (HRA, HMO or HDHP) and did not keep your 2012 Wellness Promise (see page 11 for details), you will be enrolled in the Standard Plan with your current Option (HRA, HMO or HDHP).

Note: The Tobacco Surcharge will apply only if it is currently being assessed. If your answer to the Tobacco Surcharge changes, you must notify SHBP.

Note: Spousal surcharge will no longer apply. See Plan Changes for more information.

Making Changes When You Have a Qualifying Event

If you experience a qualifying event, you may be able to make changes for yourself and your dependents if you make the request within the required time period of the qualifying event which in most cases is 31 days. Please refer to page 29. For a complete description of qualifying events, see your Summary Plan Description (SPD) available online at www.dch.georgia.gov/shbp. You may also contact the Eligibility Call Center for assistance at **800-610-1863**.



IMPORTANT NOTE

If you change options or vendors during the year, any amounts applied toward your deductible or out-of-pocket are not transferred to the new option.

A yellow sticky note with a red pushpin at the top center. The word "Important!" is written on the note in a black, handwritten-style font.

Plan Changes for 2013

Announcing NEW Plan Changes

All Plans

Most rates will increase in 2013. The rates are posted online at www.dch.georgia.gov/shbp.

All Non MA Options

Spousal Surcharge

The spousal surcharge will no longer apply. SHBP has changed its policy and will no longer assess any spousal surcharges. Currently the State subsidizes employee premiums at about 75 percent. However; due to claims costs, the current premiums are not adequate to maintain this split. Therefore, the subsidy will be less than in previous years and on an average, members will pay more to cover a spouse. The Board of Community Health establishes all premiums and subsidy policies by resolution, and may change premiums and subsidy policies at any time with advanced notice. All Board resolutions are posted at www.dch.georgia.gov.

Deductibles and Out-of-Pocket Maximum

All Options will see changes in deductibles and out-of-pocket expenses. Refer to the Benefit Charts for the changes.

Elimination of the Error Reporting Policy

SHBP will no longer accept the Error Reporting Form. You will have to file an appeal if you find that you made an error when you made your health care election for the 2013 Plan Year.



HMO, HRA, HDHP Wellness and Standard Options

UHC HMO/HRA/HDHP Wellness and Standard Options Premiums are Higher than Cigna HMO/HRA/HDHP

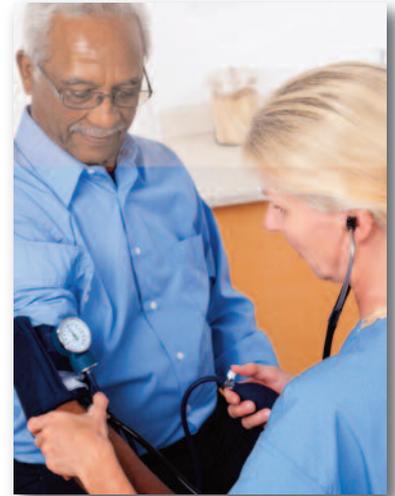
The SHBP's costs for UHC are slightly higher than that of Cigna. Therefore, the premiums for UHC Options will be slightly higher than premiums for the same Cigna Options.

HRA Wellness Option

Wellness Plan members will no longer receive the \$125 HRA fund contribution in 2013 for completing the Health Assessment and obtaining an annual physical.

HMO Standard Option Co-payment

The co-payment for a Primary Care Physician will increase from \$45 to \$55, a Specialist from \$55 to \$65 and an Urgent Care visit from \$35 to \$55.



High Deductible Health Plan (HDHP) Wellness and Standard Options

The High Deductible Health Plan (HDHP) Wellness and Standard Options are creditable. This means that the prescription drug coverage under these Plans is on average as good as that under a Medicare Part D Prescription Drug Plan.

Childhood Obesity

January 1, 2013, SHBP will provide coverage for four visits with a Primary Care Physician and four visits with a registered dietician for children between the ages of 3 and 18 who qualify as determined by their physician. Contact your health care vendor for information about the criteria for this coverage.

Preventive Care

Treatment properly coded as preventive care is covered at 100% under all Plan options. In accordance with the Patient Protection and Affordable Care Act, certain women's healthcare services are now considered preventive care when properly coded. These services include contraceptive products and services, routine prenatal screenings and breastfeeding equipment and supplies. Contact the vendors' pre-enrollment website, Cigna, at www.mycigna.com/shbp and UnitedHealthcare at www.welcometouhc.com/shbp.

Standard Plan Options

SHBP will continue to offer members the HRA, HMO and HDHP Standard Plans. The same services are covered under these Plans but under the Standard Plans, members will pay higher premiums, co-payments, deductibles and out-of-pocket expenses. The Disease Management Pharmacy Co-payment/Co-insurance Waiver Program does not apply to the Standard Plans.

You should carefully compare the benefits under each plan before making your election.

Wellness Plans for 2013



The 2013 Wellness Plan Options offered by SHBP are part of a multi-year Wellness Program. Each year, those SHBP members selecting one of the Wellness Plan Options promise to take additional steps toward better health than those members who enroll in a Standard Plan Option. Enrollment in a Wellness Plan Option is voluntary. Those members who do not select a Wellness Plan Option and instead select one of the Standard Plan Options will not be required to take any additional steps.

In 2012, SHBP began offering Wellness Plan Options, making 2013 year two of the SHBP multi-year Wellness Program. Members enrolling in a 2012 Wellness Plan Option made the 2012 Wellness Promise which required those members and spouses (if covered) to complete online health assessments through their Plan vendor (Cigna or UnitedHealthcare) and biometric screenings (including body mass index (BMI), blood pressure, cholesterol, and glucose). Members enrolled in a 2012 Wellness Plan Option received a discount in premiums and richer plan benefits.



The focus of the 2013 Plan is to encourage SHBP members to take actions intended to improve their health. Members enrolling in a Wellness Plan Option will make the 2013 Wellness Promise for themselves and their spouses (if covered).

SHBP is pleased to announce a new Member Education Portal which will include a series of educational modules which focus on various health and wellness topics. The portal will be open January 1, 2013 to any SHBP Cigna or UnitedHealthcare member in the Wellness or Standard Plans.

If those members or spouses (if covered) enrolled in a 2012 Wellness Plan Option did not meet the requirements of the 2012 Wellness Promise, the member is not eligible to enroll in a 2013 Wellness Plan Option.

2013 Wellness Plan Requirements

Members who met the 2012 Wellness Promise selecting a 2013 Wellness Plan option

Members enrolling in a 2013 Wellness Plan Option will make the 2013 Wellness Promise, requiring them to take the following **two** actions:

1. The member and spouse (if covered) must each complete their vendor's (Cigna or UnitedHealthcare) online Health Assessment through www.mycigna.com or www.myuhc.com between January 1, 2013, and May 31, 2013 and print a copy of the Confirmation of Completion; and
2. The member and spouse (if covered) must each complete a health education module through the new SHBP Member Education Portal at www.AHealthierSHBP.com between January 1, 2013, and May 31, 2013.

Note: Members who met the 2012 Wellness Promise selecting a 2013 Wellness Plan option do **not** need to do another biometric screening.

Members who are new to the Wellness Program selecting a 2013 Wellness Plan option

Members enrolling in a 2013 Wellness Plan option who were **not** enrolled in a 2012 Wellness Plan option will make the 2013 Wellness Promise, requiring them to take the following **three** actions:

1. The member and spouse (if covered) must each complete a health education module through the new SHBP Member Education Portal at www.AHealthierSHBP.com between January 1, 2013, and May 31, 2013;
2. The member and spouse (if covered) must each complete their vendor's (Cigna or UnitedHealthcare) online Health Assessment through www.mycigna.com or www.myuhc.com between January 1, 2013, and May 31, 2013 and print a copy of the Confirmation of Completion; and
3. The member and spouse (if covered) must each complete a biometric screening (including body mass index (BMI), blood pressure, cholesterol, and glucose) through a physician's office between July 1, 2012, and May 31, 2013, with the completed and signed physician screening form showing the test results faxed to the number shown on the form between November 1, 2012, and May 31, 2013

NOTE: The deadline to complete and submit the requirements of the 2013 Wellness Promise is 4:30 p.m. EST on May 31, 2013.

2014 Incentives and Requirements

In 2014, SHBP will be moving from "promise-based" incentives to "action-based" incentives. As part of this progression, SHBP will reward members with HRA incentive fund contributions for their completion of certain required health actions.

Those members and spouses (if covered) enrolled in a 2013 Wellness Plan Option will each be eligible to earn a \$240 HRA incentive fund contribution for 2014 if either meet the 2013 Wellness Promise requirements, as outlined above.

Those members and spouses (if covered) enrolled in a 2013 Standard Plan Option will also each be eligible to earn the \$240 HRA incentive fund contribution for 2014 if either take the following **three** actions:

1. Complete their vendor's (Cigna or UnitedHealthcare) online Health Assessment through www.mycigna.com or www.myuhc.com between January 1, 2013, and May 31, 2013 and print a copy of the Confirmation of Completion;
2. Complete a biometric screening if one was not completed and submitted in 2012, (including body mass index (BMI), blood pressure, cholesterol, and glucose) at a physician's office between July 1, 2012, and May 31, 2013, with the completed and signed physician screening form showing the test results faxed to the number shown on the form between November 1, 2012, and May 31, 2013; and
3. Complete a health education module through the new SHBP Member Education Portal at www.AHealthierSHBP.com between January 1, 2013, and May 31, 2013.

Note: ALL required actions must be completed by the member and spouse (if covered) by May 31, 2013, 4:30 p.m. EST in order to earn HRA incentive fund contributions for 2014. Those members and spouses (if covered) who both complete **all** required actions by the dates stated above will each be awarded the \$240 HRA incentive fund contribution (\$480 total) on January 1, 2014, and may be eligible for additional benefits as determined by SHBP in its sole discretion.

Health Coaching

SHBP members who obtain biometric screenings may have individual health issues identified. It is recommended that members follow up with their Primary Care Physician (PCP) to discuss their results and develop individual health and wellness plans.

All SHBP members, whether in the Wellness Plan or Standard Plan Options, are encouraged to participate in a telephonic or online wellness coaching programs. Wellness coaching programs such as weight management, exercise, stress management, heart health, diabetes and nutrition are currently available. Check with your vendor (Cigna or UnitedHealthcare) to learn more about their programs.

If your biometric screening results were outside of the target ranges, a nurse or health coach may reach out to you directly. A health coach is able to assist you in establishing your health goals and then help you in reaching them. Your coach will help you track your weekly progress. Keeping track of your progress will help you as you strive to reach your goals.

Note: Please be sure to keep your contact information current including your phone number, address and email to ensure that you receive all of the health coaching services and communications that are available to you.

Biometric Targets as Recommended by National Guidelines

Biometric Screening	Target Range
Cholesterol	LDL less than 130
Glucose	Fasting Blood Sugar less than 100 or A1c less than 5.7
Blood Pressure	Less than 140/90
Body Mass Index (BMI)	Less than 30

Childhood Obesity

According to the Centers for Disease Control (CDC), childhood obesity has more than tripled in the past 30 years. Obese youth are more likely to have risk factors for cardiovascular disease and more likely to have pre-diabetes. They are also at a greater risk for bone and joint problems, sleep apnea and social and psychological problems such as stigmatization and poor self-esteem.

In support of the State of Georgia's strategic goals, SHBP is now offering comprehensive health benefits to children for the treatment of childhood obesity. Beginning January 1, 2013, SHBP will provide coverage for four visits with a primary care physician and four visits with a registered dietician for children between the ages of 3 and 18 who qualify as determined by their physician. These healthcare professionals work with children and their families to establish and maintain a healthy lifestyle through in-depth nutritional counseling that can be instrumental in changing their diet and physical activity patterns.



SHBP supports adults who wish to combat their own weight issues. Both vendors provide online and telephonic weight management coaching. In addition, both vendors offer discounts for weight loss programs and for gym memberships.

All SHBP members and spouses (if covered) are eligible for three consultations with a registered dietician when diet is a part of the medical management of a documented disease. Contact Cigna or UnitedHealthcare for details about this benefit.

Additional Wellness Resources

For Cigna go to: www.cigna.com/shbp

For UnitedHealthcare go to: www.welcometouhc.com/shbp

Plan Options for 2013



Whether you are enrolled in one of the Wellness or Standard Plan Options, the Plans provide a statewide and national network of providers across the United States. None of the Plan Options require the selection of a Primary Care Physician (PCP) or referrals to a Specialist (SPC). In addition, there are no lifetime maximums and all preventive care benefits are covered at 100% when you use in-network providers only and when filed with appropriate wellness codes.

Please keep in mind, if you change options or vendors (Cigna or UHC) during the year, any amounts applied toward your deductible or out-of-pocket are not transferred to the new Option.

Health Maintenance Organization (HMO)

Understanding Your Plan Options

A HMO provides coverage for the treatment of illness including pharmacy coverage only when using in-network providers (except in cases of emergencies). This Plan features certain services that are subject to a deductible and co-insurance which count toward your out-of-pocket maximum. However, co-payments do not count toward your deductible or out-of-pocket maximum. Although you are not required to obtain a referral to a SPC, you are encouraged to select a PCP to help coordinate your care.

Health Reimbursement Arrangement (HRA)

The HRA is a Consumer-Driven Health Plan Option (CDHP) that includes a SHBP funded health reimbursement account that provides first dollar coverage for eligible health care and pharmacy expenses. Because this Plan has a deductible that must be satisfied and co-insurance amounts used to meet your out-of-pocket maximum, the amount funded by SHBP into your HRA is used to help offset some of your initial upfront costs. **Pharmacy claims are not applied to the deductible or out-of-pocket maximum including any amounts paid out of your HRA fund for pharmacy expenses.**

To illustrate how this works, the following is an example of how your HRA fund can help lower some of your medical out-of-pocket expenses. In the new Wellness Plan Option with family coverage, the money funded by SHBP can help cover the first \$1,500 of your deductible. This will lower your family deductible of \$4,000 to \$2,500. Once the remainder of the deductible has been satisfied, the Plan pays 85% of your in-network expenses or 60% of your out-of-network expenses until you reach your out-of-pocket maximum. Once your out-of-pocket maximum has been met, the Plan pays at 100%.

Any unused dollars in your HRA roll over to the next Plan Year if you are still participating in this Option, but will be forfeited if you change options during the OE or due to a qualifying event.

One special benefit for enrolling in the Wellness HMO or Wellness HRA Plans is that certain drug costs are waived if SHBP is primary and you participate and remain compliant in one of the Disease State Management (DSM) Programs for Diabetes, Asthma and/or Coronary Artery Disease.

High Deductible Health Plan (HDHP)

The HDHP Option offers in-network and out-of-network benefits and provides access to a network of providers on a statewide and national basis across the United States. This Plan has a low monthly premium but you must satisfy a separate in-network and out-of-network deductible and in-network and out-of-network out-of-pocket maximum. The deductible applies to all eligible health care expenses including pharmacy before benefits are paid. **If you cover dependents, you must meet the ENTIRE deductible before benefits are payable for any covered member. You pay co-insurance after you have satisfied the deductible rather than set dollar co-payments for medical expenses and prescription drugs until the out-of-pocket maximum is met.** Also, you may qualify to start a Health Savings Account (HSA) to set aside tax-free dollars to pay for eligible health care expenses now or in the future. HSAs typically earn interest and may even offer investment options. See the Benefits Comparison chart that starts on page 20 to compare benefits under the HDHP to other Plan Options. Go to www.irs.gov/publications/p969 for more information.

Health Savings Account (HSA) – Information Only

An HSA is like a personal savings account with investment options for health care, except it's all tax-free. You may open an HSA with a bank or an independent HSA administrator/custodian.

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

- You can contribute up to \$3,250 single, \$6,450 family as long as you are enrolled in the HDHP. These limits are set by federal law. Unused money in your account carries forward to the next Plan Year and earns interest
- HSA dollars can be used for eligible health care expenses even if you are no longer enrolled in the HDHP or any SHBP coverage
- HSA dollars can be used to pay for health care expenses (medical, dental, vision and over-the-counter medications when a doctor states they are medically necessary) that the IRS considers tax-deductible and are NOT covered by any health plan (see IRS Publication 502 at www.irs.gov)
- You can contribute an additional \$1,000 if you are 55 or older (see IRS Publication 969 at www.irs.gov)

TRICARE Supplement for Eligible Military Members

The TRICARE Supplement Plan is an alternative to SHBP coverage that is offered to employees and dependents who are eligible for SHBP coverage and enrolled in TRICARE. The TRICARE Supplement Plan is not sponsored by the SHBP, the Department of Community Health or any employer. The TRICARE Supplement Plan is sponsored by the American Military Retirees Association (AMRA) and is administered by the Association & Society Insurance Corporation. In general, to be eligible, the employee and dependents must each be under age 65, ineligible for Medicare and registered in the Defense Enrollment Eligibility Reporting System (DEERS). For complete information about eligibility and benefits, contact **866-637-9911** or visit www.asicorporation.com/ga_shbp. You may also find information at www.dch.georgia.gov/shbp.

The TRICARE Supplement Plan works with TRICARE to pay the balance of covered medical expenses after TRICARE pays. The TRICARE Supplement Plan helps to pay 100% of members' TRICARE outpatient deductible, cost share, co-payments plus 100% of covered excess charges. Members have flexibility and freedom of choice in selecting civilian providers (physicians, specialists, hospitals and pharmacies).

IMPORTANT INFORMATION



Important!

- Neither SHBP or ASI can verify eligibility for TRICARE or register you or your dependents in DEERS. Only the employee, spouse or dependent child age 18 or older can verify eligibility and register in DEERS. To verify eligibility and register in DEERS, contact DEERS at **800-538-9552**
- Employers are prohibited by law from paying any portion of the cost of TRICARE Supplement Coverage
- If you enroll in the Tricare Supplement and are not eligible for Tricare, you will be enrolled with your previous vendor in the standard option which includes the tobacco surcharge if you were paying for it before enrollment in the Tricare Supplement. If the standard option is not offered, you will be put in the standard HMO. You will be required to pay the premiums for the standard option retroactive to your date of ineligibility or your coverage will be terminated effective January 1, 2013.

Points to Consider if You Elect TRICARE Supplement Plan Coverage

- Effective January 1, 2013, TRICARE will become your primary coverage
- TRICARE Supplement Plan will become the secondary coverage
- The eligibility rules and benefits described in the TRICARE Supplement Plan will apply
 - Unmarried adult children under the age of 26 who are no longer eligible for regular TRICARE must be enrolled in TRICARE Young Adult (TYA) through TRICARE before enrolling in the TRICARE Supplement Plan
 - Unmarried children under the age of 21 or 23 if a full-time student who are no longer eligible for regular TRICARE must be enrolled in TRICARE Young Adult (TYA) through TRICARE before enrolling in the TRICARE Supplement Plan
- Tobacco Surcharge will not apply
- COBRA rights will not apply
- If you or your dependents lose eligibility for SHBP coverage while you are enrolled in the TRICARE Supplement Plan, you will be offered a portability feature by the Association & Society Insurance Corporation (ASI), administrator of TRICARE Supplement
- Loss of eligibility for the TRICARE Supplement Plan is a qualifying event. If you continue to be eligible for coverage under the SHBP, you may enroll in an SHBP Option outside of the Open Enrollment period if you make a request within 31 days of losing eligibility for the TRICARE Supplement Plan
- Attainment of age 65 and eligibility for Medicare causes a loss of eligibility for TRICARE Supplement Plan coverage. This is a qualifying event and retirees must make a request within 31 days in order to re-enroll in an SHBP coverage option
- Retirees who elect TRICARE Supplement Plan coverage may discontinue TRICARE Supplement Plan coverage and re-enroll in SHBP coverage in the future as long as they maintain continuous coverage with either the TRICARE Supplement Plan or SHBP coverage and properly submit the required change forms to SHBP during the ROCP



Questions about eligibility or benefits should be addressed to ASI at www.asicorporation.com/ga_shbp or call **866-637-9911**.

PEACHCARE FOR KIDS®

As state or public school retirees, you could be eligible to enroll your children in PeachCare for Kids. You can save more than \$2,000 per year by enrolling your children in high-quality PeachCare for Kids instead of the State Health Benefit Plan.

PeachCare for Kids provides great coverage, including vision, dental, check-ups, prescription medicine and more. Your premiums may be lower and there are no deductibles. The current monthly cost for PeachCare for Kids for one child ranges from \$10 to \$35 with a maximum of \$70 for two or more children living in the same household. There are no premiums for children under age 6.

PeachCare for Kids			
Monthly Premiums (Based on HMO example)	Current SHBP Options (Approximate monthly premium for child/children)	PeachCare for Kids (Approximate monthly premium)	Annual Savings with PeachCare for Kids
One child	\$171 to \$205 (1 child or more)	\$10 to \$35 (\$70 maximum for 2 or more children)	\$1,932 to \$2,040
Children under age 6	\$171 to \$205	FREE!	\$2,052 to \$2,460

Eligibility depends on household income. A family of three earning \$44,868 annually or a family of four earning \$54,180 may qualify. PeachCare for Kids will have an income calculator to help you determine if your children are eligible for this program.

PeachCare for Kids Benefits for Families

- PeachCare for Kids is high-quality, low-cost health care for kids ages 0 to 19
- State and public school retirees can apply for PeachCare for Kids
- Significantly reduce your out-of-pocket costs by switching your child's, or children's health care benefits from the State Health Benefit Plan to PeachCare for Kids
- PeachCare for Kids has low or no co-payments
- PeachCare for Kids has no deductibles
- For an eligible single parent, PeachCare for Kids may save more than \$200 per month
- PeachCare for Kids includes free dental and vision care
- PeachCare for Kids includes free mental health services
- Children under age 6 are free (no premiums)
- Children ages 6 to 19 have low premiums (\$35 for one child; maximum of \$70 total for two or more children)
- All major medical, including hospitalization, is covered by PeachCare for Kids
- Your physician may already be a PeachCare for Kids provider

If your children are eligible and you enroll them in PeachCare for Kids, SHBP will be notified of the enrollment effective date and will change your premiums (if your enrollment tier will change) and terminate your child's SHBP coverage because children cannot be covered under both SHBP and PeachCare for Kids. Once children are approved for PeachCare, employees should verify that the correct deduction is being taken.

If your child loses PeachCare for Kids coverage, you have 60 days from the loss of coverage to enroll your child in SHBP. It is not a qualifying event to enroll your children in SHBP if PeachCare for Kids denies enrollment or if coverage under PeachCare ends because of failure to pay the monthly premiums. Do not discontinue your child's coverage in SHBP until you receive confirmation that PeachCare for Kids has approved his/her enrollment.

The PeachCare for Kids enrollment process can take up to four weeks — so apply now so coverage will go into effect once approved.

Visit www.peachcare.org or call **1-877-427-3224** for more information.



2013 Plan Options

Benefits Comparison: HRA—HDHP—HMO Plans

Schedule of Benefits for You and Your Dependents for January 1, 2013 – December 31, 2013

Covered Services	Wellness HRA Option		Wellness HDHP Option	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Deductible/Co-Payments				
• You	\$1,600*		\$1,800	\$3,600
• You + Spouse	\$2,800*		\$3,600	\$7,200
• You + Child(ren)	\$2,800*		\$3,600	\$7,200
• You + Family	\$4,000*		\$3,600	\$7,200
	*HRA credits will reduce this amount			
Out-of-Pocket Maximum				
• You	\$4,000*		\$4,000	\$8,000
• You + Spouse	\$6,500*		\$8,000	\$16,000
• You + Child(ren)	\$6,500*		\$8,000	\$16,000
• You + Family	\$9,000*		\$8,000	\$16,000
	*HRA credits will reduce this amount			
HRA Credits			None	
• You	\$500			
• You + Spouse	\$1,000			
• You + Child(ren)	\$1,000			
• You + Family	\$1,500			
Physicians' Services	The Plan Pays		The Plan Pays	
Primary Care Physician or Specialist Office or Clinic Visits Treatment of illness or injury	85% coverage; subject to deductible	60% coverage; subject to deductible	90% coverage; subject to deductible	60% coverage; subject to deductible
Maternity Care (prenatal, delivery and postpartum)				
Primary Care Physician or Specialist Office or Clinic Visits for the Following:	100% coverage; not subject to deductible	Not covered	100% coverage; not subject to deductible	Not covered
• Wellness care/preventive health care				
• Annual gynecological exams (these services are not subject to the deductible)				
• Prenatal care coded as preventative				
Physician Services Furnished in a Hospital • Visits; surgery in general, including charges by surgeon, anesthesiologist, pathologist and radiologist	85% coverage; subject to deductible	60% coverage; subject to deductible	90% coverage; subject to deductible	60% coverage; subject to deductible
Physician Services for Emergency Care	85% coverage; subject to deductible		90% coverage; subject to in-network deductible	
Allergy Shots and Serum	85% coverage; subject to deductible	60% coverage; subject to deductible	90% coverage; subject to deductible	60% coverage; subject to deductible

Wellness HMO Option	Standard HRA Option		Standard HDHP Option		Standard HMO Option
In-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network
\$1,300 \$1,950 \$1,950 \$2,600	\$1,600* \$2,800* \$2,800* \$4,000*		\$2,000 \$4,000 \$4,000 \$4,000	\$4,000 \$8,000 \$8,000 \$8,000	\$1,300 \$1,950 \$1,950 \$2,600
	<i>*HRA credits will reduce this amount</i>				
\$4,000+Co-pays \$6,500+Co-pays \$6,500+Co-pays \$9,000+Co-pays	\$4,500* \$7,000* \$7,000* \$9,500*		\$4,500 \$9,000 \$9,000 \$9,000	\$9,000 \$18,000 \$18,000 \$18,000	\$4,500+Co-pays \$7,000+Co-pays \$7,000+Co-pays \$9,500+Co-pays
	<i>*HRA credits will reduce this amount</i>				
None	\$150 \$300 \$300 \$500		None	None	None
The Plan Pays	The Plan Pays		The Plan Pays		The Plan Pays
100% after a \$35 PCP or \$45 SPC per office visit co-payment	85% coverage; subject to deductible	60% coverage; subject to deductible	80% coverage; subject to deductible	60% coverage; subject to deductible	100% after a \$55 PCP or \$65 SPC per office visit co-payment
100% coverage; not subject to deductible	100% coverage; not subject to deductible	Not covered	100% coverage; not subject to deductible	Not covered	100% coverage; not subject to deductible
80% coverage; subject to deductible	85% coverage; subject to deductible	60% coverage; subject to deductible	80% coverage; subject to deductible	60% coverage; subject to deductible	80% coverage; subject to deductible
100% (\$150 co-payment applies to facility expenses)	85% coverage; subject to deductible		80% coverage; subject to in-network deductible		100% (\$150 co-payment applies to facility expenses)
100% for shots and serum after a \$35 PCP or \$45 SPC per visit co-payment; no co-payment if office visit not billed	85% coverage; subject to deductible	60% coverage; subject to deductible	80% coverage; subject to deductible	60% coverage; subject to deductible	100% for shots and serum after a \$55 PCP or \$65 SPC per visit co-payment; no co-payment if office visit not billed

2013 Plan Options

Benefits Comparison: HRA—HDHP—HMO Plans

Schedule of Benefits for You and Your Dependents for January 1, 2013 – December 31, 2013

	Wellness HRA Option		Wellness HDHP Option	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Physicians' Services	<i>The Plan Pays</i>		<i>The Plan Pays</i>	
Outpatient Surgery • When billed as office visit	85% coverage; subject to deductible	60% coverage; subject to deductible	90% coverage; subject to deductible	60% coverage; subject to deductible
Outpatient Surgery • When billed as outpatient surgery at a facility	85% coverage; subject to deductible	60% coverage; subject to deductible	90% coverage; subject to deductible	60% coverage; subject to deductible
Hospital Services	<i>The Plan Pays</i>		<i>The Plan Pays</i>	
Inpatient Services • Inpatient care, delivery and inpatient short-term acute rehabilitation services	85% coverage; subject to deductible	60% coverage; subject to deductible	90% coverage; subject to deductible	60% coverage; subject to deductible
Inpatient Services • Well-newborn care	85% coverage; subject to deductible	60% coverage; subject to deductible	90% coverage; subject to deductible	60% coverage; subject to deductible
Outpatient Surgery Hospital/facility	85% coverage; subject to deductible	60% coverage; subject to deductible	90% coverage; subject to deductible	60% coverage; subject to deductible
Emergency Care—Hospital • Treatment of an emergency medical condition or injury	85% coverage; subject to deductible		90% coverage; subject to in-network deductible	
Outpatient Testing, Lab, etc.	<i>The Plan Pays</i>		<i>The Plan Pays</i>	
Non Routine laboratory; X-Rays; Diagnostic Tests; Injections • Including medications covered under medical benefits—for the treatment of an illness or injury	85% coverage; subject to deductible	60% coverage; subject to deductible	90% coverage; subject to deductible	60% coverage; subject to deductible

Wellness HMO Option	Standard HRA Option		Standard HDHP Option		Standard HMO Option
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network
The Plan Pays	The Plan Pays		The Plan Pays		The Plan Pays
100% (\$35 PCP or \$45 SPC co-payment if billed as office visit)	85% coverage; subject to deductible	60% coverage; subject to deductible	80% coverage; subject to deductible	60% coverage; subject to deductible	100% (\$55 PCP or \$65 SPC co-payment if billed as office visit)
80% coverage; subject to deductible	85% coverage; subject to deductible	60% coverage; subject to deductible	80% coverage; subject to deductible	60% coverage; subject to deductible	80% coverage; subject to deductible
The Plan Pays	The Plan Pays		The Plan Pays		The Plan Pays
80% coverage; subject to deductible	85% coverage; subject to deductible	60% coverage; subject to deductible	80% coverage; subject to deductible	60% coverage; subject to deductible	80% coverage; subject to deductible
100% coverage; not subject to deductible	85% coverage; subject to deductible	60% coverage; subject to deductible	80% coverage; subject to deductible	60% coverage; subject to deductible	100% coverage; not subject to deductible
80% coverage; subject to deductible	85% coverage; subject to deductible	60% coverage; subject to deductible	80% coverage; subject to deductible	60% coverage; subject to deductible	80% coverage; subject to deductible
100% after a \$150 per visit co-payment; if admitted, co-payment waived	85% coverage; subject to deductible		80% coverage; subject to in-network deductible		100% after a \$150 per visit co-payment; if admitted, co-payment waived
The Plan Pays	The Plan Pays		The Plan Pays		The Plan Pays
80% coverage; subject to deductible	85% coverage; subject to deductible	60% coverage; subject to deductible	80% coverage; subject to deductible	60% coverage; subject to deductible	80% coverage; subject to deductible

2013 Plan Options

Benefits Comparison: HRA—HDHP—HMO Plans

Schedule of Benefits for You and Your Dependents for January 1, 2013 – December 31, 2013

	Wellness HRA Option		Wellness HDHP Option	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Behavioral Health	<i>The Plan Pays</i>		<i>The Plan Pays</i>	
Mental Health and Substance Abuse Inpatient Facility and Partial Day Hospitalization	85% coverage; subject to deductible	60% coverage; subject to deductible	90% coverage; subject to deductible	60% coverage; subject to deductible
	Contact vendor regarding prior authorization			
Mental Health and Substance Abuse Outpatient Visits and Intensive Outpatient	85% coverage; subject to deductible	60% coverage; subject to deductible	90% coverage; subject to deductible	60% coverage; subject to deductible
	Contact vendor regarding prior authorization			
Other Coverage	<i>The Plan Pays</i>		<i>The Plan Pays</i>	
Outpatient Acute Short-Term Rehabilitation Services • Physical Therapy • Speech Therapy • Occupational Therapy • Other short term rehabilitative services	85% coverage; subject to deductible; up to 40 visits per therapy per Plan Year (not to exceed a total of 40 visits combined, including any out-of-network visits)	60% coverage; subject to deductible; up to 40 visits per therapy per Plan Year (not to exceed a total of 40 visits combined, including any in-network visits)	90% coverage up to 40 visits per therapy per Plan Year; subject to deductible (not to exceed a total of 40 visits combined, including any out-of-network visits)	60% coverage up to 40 visits per therapy per Plan Year; subject to deductible (not to exceed a total of 40 visits combined, including any in-network visits)
Chiropractic Care NOTE: UHC Coverage up to a maximum of 20 visits; CIGNA – up to a maximum of 20 days, per Plan Year	85% coverage; subject to deductible	60% coverage; subject to deductible	90% coverage; subject to deductible	60% coverage; subject to deductible
Hearing Services Routine hearing exam	85% coverage for routine exam and fitting; subject to deductible. \$1,500 hearing aid allowance every 5 years; not subject to the deductible		90% coverage for routine exam and fitting; subject to deductible. \$1,500 hearing aid allowance every 5 years; subject to the deductible	
Urgent Care Services NOTE: All subject to deductible except HMO	85% coverage; subject to deductible	60% coverage; subject to deductible	90% coverage; subject to deductible	60% coverage; subject to deductible
Pharmacy - You Pay				
Tier 1 Co-payment	15% (\$20 min/\$50 max) not subject to deductible	40% coverage; not subject to deductible*	20% coverage; subject to deductible \$10 min/\$100 max	Not covered
Tier 2 Co-payment Preferred Brand	25% (\$50 min/\$80 max) not subject to deductible	40% coverage; not subject to deductible*	20% coverage; subject to deductible \$10 min/\$100 max	Not covered
Tier 3 Co-payment Non-Preferred Brand	25% (\$80 min/\$125 max) not subject to deductible	40% coverage; not subject to deductible*	20% coverage; subject to deductible \$10 min/\$100 max	Not covered
90-Day Voluntary Mail Order	Tier 1–15% (\$50 min/\$125 max) Tier 2–25% (\$125 min/\$200 max) Tier 3–25% (\$200 min/\$312.50 max) *Does not apply to deductible or out-of-pocket max		20% (\$25 min/\$250 max) No non-network coverage	

Wellness HMO Option	Standard HRA Option		Standard HDHP Option		Standard HMO Option
In-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network
<i>The Plan Pays</i>	<i>The Plan Pays</i>		<i>The Plan Pays</i>		<i>The Plan Pays</i>
80% coverage; subject to deductible	85% coverage; subject to deductible	60% coverage; subject to deductible	80% coverage; subject to deductible	60% coverage; subject to deductible	80% coverage; subject to deductible
Contact vendor regarding prior authorization					
100% after \$45 SPC per visit co-payment. \$10 co-payment for group therapy	85% coverage; subject to deductible	60% coverage; subject to deductible	80% coverage; subject to deductible	60% coverage; subject to deductible	100% after \$65 SPC per visit co-payment. \$10 co-payment for group therapy
Contact vendor regarding prior authorization					
<i>The Plan Pays</i>	<i>The Plan Pays</i>		<i>The Plan Pays</i>		<i>The Plan Pays</i>
100% coverage after \$25 per visit co-payment; up to 40 visits per therapy per Plan Year	85% coverage; subject to deductible; up to 40 visits per therapy per Plan Year (not to exceed a total of 40 visits combined, including any out-of-network visits)	60% coverage; subject to deductible; up to 40 visits per therapy per Plan Year (not to exceed a total of 40 visits combined, including any in-network visits)	80% coverage up to 40 visits per therapy per Plan Year; subject to deductible (not to exceed a total of 40 visits combined, including any out-of-network visits)	60% coverage up to 40 visits per therapy per Plan Year; subject to deductible (not to exceed a total of 40 visits combined, including any in-network visits)	100% coverage after \$25 per visit co-payment; up to 40 visits per therapy per Plan Year
100% coverage after \$45 SPC co-payment per visit	85% coverage; subject to deductible	60% coverage; subject to deductible	80% coverage; subject to deductible	60% coverage; subject to deductible	100% coverage after \$65 SPC co-payment per visit
Not covered	85% coverage for routine exam and fitting; subject to deductible. \$1,500 hearing aid allowance every 5 years; not subject to the deductible		80% coverage for routine exam and fitting; subject to deductible. \$1,500 hearing aid allowance every 5 years; subject to the deductible		Not covered
100% after \$35 co-payment	85% coverage; subject to deductible	60% coverage; subject to deductible	80% coverage; subject to deductible	60% coverage; subject to deductible	100% after \$55 co-payment
\$20	15% (\$20 min/\$50 max) not subject to deductible	40% coverage; not subject to deductible*	20% coverage; subject to deductible \$10 min/\$100 max	Not covered	\$20
\$50	25% (\$50 min/\$80 max) not subject to deductible	40% coverage; not subject to deductible*	20% coverage; subject to deductible \$10 min/\$100 max	Not covered	\$50
\$90	25% (\$80 min/\$125 max) not subject to deductible	40% coverage; not subject to deductible*	20% coverage; subject to deductible \$10 min/\$100 max	Not covered	\$90
Tier 1—\$50 Tier 2—\$125 Tier 3—\$225	Tier 1—15% (\$50 min/\$125 max) Tier 2—25% (\$125 min/\$200 max) Tier 3—25% (\$200 min/\$312.50 max) *Does not apply to deductible or out-of-pocket max		20% (\$25 min/\$250 max) No non-network coverage		Tier 1—\$50 Tier 2—\$125 Tier 3—\$225

2013 Plan Options

Benefits Comparison: HRA—HDHP—HMO Plans

Schedule of Benefits for You and Your Dependents for January 1, 2013 – December 31, 2013

	Wellness HRA Option		Wellness HDHP Option	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Other Coverage	<i>The Plan Pays</i>		<i>The Plan Pays</i>	
Home Health Care Services NOTE: Prior approval required	85% coverage; subject to deductible	60% coverage; subject to deductible	90% coverage; subject to deductible	60% coverage; subject to deductible
Skilled Nursing Facility Services NOTE: Prior approval required	85% coverage; up to 120 days per Plan Year; subject to deductible	Not covered	90% coverage up to 120 days per Plan Year; subject to deductible	Not covered
Hospice Care NOTE: Prior approval required	85% coverage; subject to deductible	60% coverage; subject to deductible	90% coverage; subject to deductible	60% coverage; subject to deductible
Durable Medical Equipment (DME)—Rental or purchase NOTE: Prior approval required for certain DME	85% coverage; subject to deductible	60% coverage; subject to deductible	90% coverage; subject to deductible	60% coverage; subject to deductible
Foot Care NOTE: Covered only for neurological or vascular diseases	85% coverage; subject to deductible	60% coverage; subject to deductible	90% coverage; subject to deductible	60% coverage; subject to deductible
Transplant Services NOTE: Prior approval required	Contact vendor for coverage details			

Wellness HMO Option	Standard HRA Option		Standard HDHP Option		Standard HMO Option
In-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network
<i>The Plan Pays</i>	<i>The Plan Pays</i>		<i>The Plan Pays</i>		<i>The Plan Pays</i>
100% coverage; UHC up to 120 visits; CIGNA up to 120 days per Plan Year	85% coverage; subject to deductible	60% coverage; subject to deductible	80% coverage; subject to deductible	60% coverage; subject to deductible	100% coverage; UHC up to 120 visits; CIGNA up to 120 days per Plan Year
80% coverage; up to 120 days per Plan Year; subject to deductible	85% coverage; up to 120 days per Plan Year; subject to deductible	Not covered	80% coverage up to 120 days per Plan Year; subject to deductible	Not covered	80% coverage; up to 120 days per Plan Year; subject to deductible
100% coverage; subject to deductible	85% coverage; subject to deductible	60% coverage; subject to deductible	80% coverage; subject to deductible	60% coverage; subject to deductible	100% coverage; subject to deductible
100% coverage when medically necessary	85% coverage; subject to deductible	60% coverage; subject to deductible	80% coverage; subject to deductible	60% coverage; subject to deductible	100% coverage when medically necessary
100% coverage after \$35 PCP or \$45 SPC co-payment per visit	85% coverage; subject to deductible	60% coverage; subject to deductible	80% coverage; subject to deductible	60% coverage; subject to deductible	100% coverage after \$55 PCP or \$65 SPC co-payment per visit

Contact vendor for coverage details

SHBP

Eligibility

The SHBP covers dependents who meet SHBP guidelines. Eligibility documentation must be submitted before SHBP can send notification of a dependent's coverage to the health care vendors.

Eligible Dependents Are:

1. **Spouse** – Individual who is not legally separated, who is of the opposite sex of the Enrolled Member and who is legally married or who submits satisfactory evidence to the Administrator of common law marriage to the Employee or Retiree entered into prior to January 1, 1997 and is not legally separated.
2. **Dependent Child** – An eligible Dependent child of an Enrolled Member must meet one of the following definitions:
 - **Natural child** – A natural child for whom the natural guardian has not relinquished all guardianship rights through a judicial decree. Eligibility begins at birth and ends at the end of the month in which the child reaches age twenty-six (26).
 - **Adopted child** – Eligibility begins on the date of legal placement for adoption and ends at the end of the month in which the child reaches age twenty-six (26).
 - **Stepchild** – Eligibility begins on the date of marriage to the natural parent. Eligibility ends at the end of the month in which the child reaches age twenty-six (26), or at the end of the month in which the stepchild loses his or her status as stepchild of the Enrolled Member, whichever is earlier.
 - **Guardianship** – A child for whom the Enrolled Member is the legal guardian. Eligibility begins on the date the legal guardianship is established. Eligibility ends at the end of the month in which the child reaches age twenty-six (26), or at the end of the month in which the legal guardianship terminates, whichever is earlier. Certification documentation requirements are at the discretion of the Administrator. However, a judicial decree from a court of competent jurisdiction is required unless the Administrator concludes that documentation is satisfactory to establish legal guardianship and that other legal papers present undue hardship on the Member or living natural parent(s).
 - **Totally Disabled Child** – A natural child, legally adopted child or stepchild age twenty-six (26) or older, if the child was physically or mentally disabled before age twenty-six (26), continues to be physically or mentally disabled, lives with the Enrolled Member or is institutionalized, and depends primarily on the Enrolled Member for support and maintenance.



Making Changes When You Have a Qualifying Event

If you experience a qualifying event, you may be able to make changes for yourself and your dependents if you make the request within the required time period of the qualifying event which in most cases is 31 days. In some cases, the time period may be extended to 60 or 90 days based on state and federal law or SHBP regulations. The requested change must correspond to the qualifying event. For a complete description of qualifying events, see your Summary Plan Description available online at www.myshbp.ga.gov. You may also contact the Eligibility Call Center for assistance at **800-610-1863**.

Qualifying events include, but are not limited to:

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

IMPORTANT NOTE

If you have single coverage and are having a baby, in order for the baby's charges to be covered, you must change tiers to include the baby at birth.



Important!

IMPORTANT INFORMATION

- Please submit your change request within the required time period, which is usually 31 days. In some cases the time period may be extended to 60 or 90 days based on state and federal law or SHBP regulations.
- Change requests should not be held waiting on additional information, such as Social Security Number, marriage or birth certificate.
- SHBP will accept dependent verification at anytime during the Plan Year and coverage will be retroactive to the qualifying event date or first of the Plan Year, whichever is later.
- No health claims will be paid until the documentation is received and approved by SHBP.
- The member's Social Security Number **MUST** be written on each document SHBP receives so we can match your dependents to your record. Do not send originals as they will not be returned.



Important!

Documentation Confirming Eligibility for Your Spouse or Dependents

SHBP requires documentation concerning eligibility of dependents covered under the plan.

- **Spouse** – Certified copy of marriage license or copy of your most recent Federal Tax Return (filed jointly with spouse) including legible signatures for you and your spouse with financial information blacked out. The spouse's Social Security Number is also required.
- **Natural or adopted child** – Certified copy of birth certificate or birth card issued by hospital which lists parents by name are accepted for new births and certified copy of court documents establishing adoption and stating date of adoption, or, if adoption is not finalized, certified or notarized legal documents establishing the date of placement for adoption. If a certified copy of the birth certificate is not available for an adopted child, other proof of the child's date of birth is required. The Social Security Number is required for all children two and older.
- **Stepchild** – Certified copy of birth certificate showing your spouse is the natural parent of the child AND certified copy of marriage license showing the natural parent of the child is your spouse or a copy of your most recent Federal Tax Return (filed jointly with spouse) including legible signatures for you and your spouse with financial information blacked out. The Social Security Number is required for all children age two and older.
- **Legal Guardianship** – Certified copy of court documents establishing the legal guardianship and stating the dates on which the guardianship begins and ends and a certified copy of the birth certificate or other proof of the child's date of birth. The Social Security Number is required for all children age two and older.

COBRA Rights – Dependents

The Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1986 requires that the Plan offer your spouse or an eligible dependent the opportunity to continue health coverage if Plan coverage is lost due to a Qualifying Event. The length of time one of your dependents may continue the coverage is based on the Qualifying Event. For further information refer to your SPD available at www.myshbp.ga.doc



If You Are Retiring

If You Are Retiring

- In order to continue your SHBP Plan as a retiree, you and any dependents you want covered must be enrolled in the Plan at the time you retire. If you are not enrolled in the SHBP coverage and wish to carry coverage as a retiree, you will need to enroll in the Plan during the Open Enrollment the year prior to your retirement.
- If you are under 65, your Options are the same as for active employees and the Tobacco Surcharge will apply.
- Once retired, you will have an annual Retiree Option Change Period (ROCP) that allows you to change your Plan Option only.
- You may add dependents only if you have a qualifying event.
- Please refer to the Retiree Decision Guide for complete details regarding your SHBP coverage and Options as a retiree.





About the Following Notice

The notice on the following pages is required by the Centers for Medicaid & Medicare Services (CMS) to explain what happens if you buy an individual Medicare Prescription Drug (Part D) Plan. The chart below explains what happens if you buy an individual Medicare Part D Plan.

This notice states that prescription drug coverage under all SHBP coverage options are considered Medicare Part D “creditable coverage.” This means generally that the prescription drug coverage under the SHBP MA Standard, SHBP MA Premium, HMO, HRA and HDHP options are all “as good or better than” the prescription drug coverage offered through Medicare Part D plans that are sold to individuals.

Your SHBP Option	What happens if you buy an individual Medicare Part D Plan
SHBP Medicare Advantage PPO Standard or SHBP Medicare Advantage PPO Premium Plan	Your MA coverage under SHBP will be terminated and we will move you to the Standard option and vendor you had before MA PPO and you will pay 100% of the premium. If the option is not offered, you will be placed in the Standard HMO of the vendor you had before the MA PPO
HRA /HMO/HDHP	Your Medicare Part D Plan will be primary for your prescription drugs unless you are in the deductible or doughnut hole and then SHBP will provide benefits. If you reach the Out-of-pocket Limit, SHBP will coordinate benefits with your Medicare Part D Plan. You will pay a Medicare “late enrollment” penalty unless the reason you didn’t enroll in Medicare Part D when you first became eligible is because you were still working

COBRA Rights – Dependents of Retirees

The Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1986 requires that the Plan offer your spouse or an eligible dependent the opportunity to continue health coverage if Plan coverage is lost due to a Qualifying Event. The length of time one of your dependents may continue the coverage is based on the Qualifying Event. For further information refer to your SPD available at www.dch.georgia.gov/shbp.

Penalties for Misrepresentation

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

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



Important Notice from the State Health Benefit Plan About Your 2013 Prescription Drug Coverage under the HDHP, HRA and HMO Options (either Standard or Wellness) offered by Cigna or UnitedHealthcare and Medicare

For Plan Year: January 1 – December 31, 2013

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with the State Health Benefit Plan (SHBP) and about your options under Medicare's prescription drug coverage.

This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. The SHBP has determined that the prescription drug coverage offered under the HMO, HRA and HDHP Standard and Wellness Plans offered by Cigna and UnitedHealthcare under SHBP are, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and are, therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can you Join a Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th. However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current SHBP coverage will be affected. If you join a Medicare drug plan and do not terminate your SHBP coverage, SHBP will coordinate benefits with the Medicare drug plan coverage the month following receipt of notice. You should send a copy of your Medicare cards to SHBP at P.O. Box 1990, Atlanta, GA 30301-1990.

Important: If you are a retiree and terminate your SHBP coverage, you will not be able to get this SHBP coverage back.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

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

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

In addition, if you don't join within 63 continuous days after your current coverage ends, you may have to wait until the following October to join.

For More Information About This Notice Or Your Current Prescription Drug Coverage...

Contact the SHBP Call Center at **1-800-610-1863**. **NOTE:** You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through SHBP changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage...

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

For more information about Medicare prescription drug coverage:

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

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

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

From: January 1, 2013 To: January 1, 2014

Date: October 1, 2012

Name of Entity/Sender: State Health Benefit Plan

Contact: Call Center

Address: 2 Peachtree Street, Atlanta, GA 30334

Phone Number: 1-800 - 610-1863



Website Available

October 9, at 4 a.m. –
November 9, 4:30 p.m.

For Plan Coverage

January 1, 2013 – December 31, 2013

The material in this booklet is for information purposes only and is not a contract. It is intended only to highlight principal benefits of the health plan Options. Every effort has been made to be as accurate as possible; however, should there be a difference between this information and the Plan documents, the Plan documents govern. For all Options other than Medicare Advantage Option, the Plan documents include the SHBP regulations, Summary Plan Descriptions and reimbursement guidelines of the vendors. The Plan documents for Medicare Advantage is the insurance certificates. It is the responsibility of each member, active or retired, to read the Plan documents in order to fully understand how that Option pays benefits. Availability of SHBP Options may change based on federal or state law changes or as approved by the Board of the Department of Community Health. Premiums for SHBP Options are established by the DCH Board and may be changed at any time by the Board resolutions subject to advance notice.



SHBP
State Health Benefit Plan