SHBP
State Health Benefit Plan

New Enrollee Decision Guide

for Plan Year 2013

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.

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

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GEORGIA DEPARTMENT
OF COMMUNITY HEALTH

David A. Cook, Commissioner Nathan Deal, Governor

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

November 1, 2012

Dear New State Health Benefit Plan Member:

Your State Health Benefit Plan (SHBP) holds opportunities for you to become more engaged with your health care. In keeping with Gov. Deal's Strategic Goals for the state, our SHBP increases personal responsibility in health care by encouraging members to adopt healthy behaviors.

New enrollees may choose between two consumer-driven health options offered by both Cigna and UnitedHealthcare (UHC), our health plan vendors. These plans are:

Cigna	UnitedHealthcare
Standard HDHP	Standard HDHP
Standard HRA	Standard HRA

Each plan's design is similar to that of a Preferred Provider Organization Plan (PPO) with in-network and out-of-network benefits, 100 percent unlimited coverage for wellness care based on national age and gender guidelines, and other enhanced benefits exclusive to these plans.

If you choose the HRA option, you will have the extra benefit of the SHBP contributing dollars to your HRA on an annual basis for payment of medical and pharmacy expenses. The HDHP has a lower monthly premium and allows members to start a Health Savings Account (HSA) to set aside tax-free dollars to pay for eligible health care expenses and offset the higher deductible.

In keeping with Gov. Deal's initiative, we also encourage new enrollees to complete the online health assessment, complete a biometric screening, and participate in your plan's online health modules and other tools designed to educate and engage members in healthier behaviors. Wellness care is included in your plans; we urge you to take advantage of this benefit.

The Georgia Department of Community Health, which administers the SHBP, is committed to providing you with choices in your options while keeping costs down. Be assured that we will continue to provide you with tools to help you make the right health care choices for you and your family members.

Sincerely,

David A. Cook
Commissioner

General Information

This guide will provide you with a brief explanation of each Plan Option.

While CIGNA and UnitedHealthcare's basic plan design is the same for each option, each vendor has nuances in benefits and services that are unique to each option. It is important that you read the Decision Guide so you will understand what these differences are and how they may affect you.

State Health Benefit Plan

The Georgia Department of Community Health (DCH), which administers the State Health Benefit Plan (SHBP), continually seeks to offer high-quality, affordable health coverage. Keep in mind, however, that you are the manager of your health care needs, and in turn, must take the time to understand your Plan benefit choices in order to make the best decisions for you and your family.

Let's start by talking about how the SHBP works. It is a self-funded plan, which means that all expenses are paid by employee premiums and employer funds. Approximately 75 percent of the cost is funded by your employer, with you paying approximately 25 percent.

People who do not understand their health coverage pay more, according to the American Medical Association. To help you better understand your Plan and save your health care dollars, we have prepared a few points for you to consider.

What Can You Do to Help Manage Your Health Care Costs?

Understand Your Options – Compare all Plan Options, considering both the premiums and out-of-pocket costs that you may incur. Web sites and phone numbers are listed on the inside of the front cover of the Decision Guide if you need more information.

Become a More Proactive Consumer of Health Care – Most people do not realize how much their treatments, medicines and tests cost.

Steps you can take include:

- Keep a list of all medications you take.
- Shop in-network providers and pharmacies.
- Find out what your drugstore charges for a drug.
- Make sure all procedures are pre-certified, if required.
- Make sure you get the results of any test or procedure.
- Understand what will happen if you need surgery.
- Check your Explanation of Benefits (if provided under your plan option) and if you have questions, ask your provider about it.

These and other steps you take will help manage healthcare expenses, reduce your out-of-pocket costs and those of the Plan. In addition, these steps will help in keeping premium costs down.

SHBP
Eligibility Information

All SHBP options have the same eligibility requirements. A summary is listed below.

SHBP Eligibility for You

You are eligible to enroll yourself and your eligible dependents for coverage if you are:

- **A full-time employee of the state of Georgia, the Georgia General Assembly, or an agency, board, commission, department, county administration or contracting employer that participates in the SHBP, as long as:**
  —You work at least 30 hours a week consistently, and
  —Your employment is expected to last at least nine months.
  Not eligible: Student employees or seasonal, part-time or short-term employees.
- **A certified public school teacher or library employee** who works half-time or more, but not less than 17.5 hours a week
  Not eligible: Temporary or emergency employees
- **A non-certified service employee of a local school system** who is eligible to participate in the Teachers Retirement System or its local equivalent. You must also work at least 60 percent of a standard schedule for your position, but not less than 20 hours a week
- **An employee who is eligible to participate in the Public School Employees' Retirement System** as defined by Paragraph 20 of Section 47-4-2 of the Official Code of Georgia, Annotated. You must also work at least 60 percent of a standard schedule for your position, but not less than 15 hours a week
- **A retired employee of one of these listed groups** who was enrolled in the Plan at retirement and is eligible to receive an annuity benefit from a state-sponsored or state-related retirement system. See the Summary Plan Description (SPD) for more information
- **An employee in other groups** as defined by law.

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 and depends primarily on the Enrolled Member for support and maintenance. See the Summary Plan Description at **www.dch.georgia.gov/shbp** or call 800-610-1863 for more information.

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:	Eligibility Questions:
• CIGNA for HRA, HMO or HDHP Options – **800-633-8519** • UHC HRA – **800-396-6515** • UHC HMO, HDHP – **877-246-4189**	• 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 health care vendor and you may want to consider using the Mail Order Program which should lower your prescription drug costs.

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

Enrolling in SHBP coverage

Before You Enroll

You should:

- Read this *Decision Guide* and Summary Plan Description to understand your Health Plan Options prior to making your health election.
- Read and understand the SHBP Tobacco Surcharge Policy on page 9 and answer the question regarding this surcharge. If you fail to answer the question, the surcharge will apply for the 2013 Plan Year unless you experience a qualifying event or you complete the applicable steps to remove the surcharge.
- Gather eligibility verification documents for all dependents for whom coverage has been requested to submit within the required time frame as described on page 22.
- Understand the election you make will be valid for the 2013 Plan Year unless you experience a qualifying event. Qualifying events are described on page 21.
- Additional options may be available to you during the Fall Open Enrollment for coverage effective January 1, 2014.

Health Benefit Cost Estimators

Choosing the right health plan is an important decision and CIGNA and UHC each provide a Plan Cost Estimator (PCE) tool to assist you. The PCEs offer you a simple way to help determine which option is best for you and your family. These online tools let you compare how your out-of-pocket expenses may vary under the different health plan options available to you.

You can use the PCE to review cost information for prescriptions, anticipated tests and procedures.

How to Enroll

If you're eligible to participate in the SHBP, you become a member by enrolling either:

- As a new hire, within 31 days of your hire date. If you join the SHBP during that first 31-day enrollment opportunity, your coverage will go into effect on the first day of the month after you complete one full calendar month of employment. See your personnel/payroll office for instructions on how to enroll or if you have benefit questions, you may call the vendor directly at the telephone numbers listed on the inside of the front cover of the Decision Guide.
- As a result of a qualifying event. *See Making Changes When You Have a Qualifying Event, page 21 of this guide for more details.*

- If you terminate employment and are re-hired by any employer eligible for the SHBP during the same Plan year, you must enroll in the same Plan option and tier (even if there is a gap in coverage) provided you are eligible for that option and have not had a qualifying event since coverage ended.
- If the termination is in one year and you are hired in the following year with a gap in coverage, you are restricted to the consumer driven health plan options: the Health Reimbursement Arrangement (HRA), High Deductible Health Plan (HDHP) Standard Options and TRICARE Supplement with the new employer.
- If you decline coverage under SHBP when you first become eligible and later decide to enroll due to a qualifying event or at a future Open Enrollment period, your options will be limited to the HRA, HDHP Standard Plans and TRICARE supplement (if eligible) for your first Plan Year of coverage.

If You Decide to Become a SHBP Member, You Will Have Two Major Choices to Make:

1. Your health care vendor and coverage option:

CIGNA Healthcare

- Standard Health Reimbursement Arrangement (HRA)
- Standard High Deductible Health Plan (HDHP)

UnitedHealthcare

- Standard Health Reimbursement Arrangement (HRA)
- Standard High Deductible Health Plan (HDHP)

2. Which eligible dependents would you like to have covered by SHBP? *For a list of eligible dependents, refer to pages 5.*

- SHBP is required to obtain the Social Security Number of each covered dependent.

3. Which coverage tier? Select the coverage tier you desire for the dependents that you choose to cover. You will be locked into the tier for the 2013 Plan Year unless you experience a qualifying event.

- You
- You + Child(ren)
- You + Spouse
- You + Family*
- SHBP requires you to submit documentation confirming eligibility of your dependents (see page 22).

**You + Family = You + Spouse + Child(ren)*

NOTE: *Additional options may be available to you during the Fall Open Enrollment period for the following Plan Year.*

What Happens if I Have Other Insurance?

You or your covered dependents may have medical coverage under more than one plan. In this case, coordination of benefits (COB) provisions apply.

IMPORTANT NOTE

When you have other group or Medicare coverage and SHBP coverage, the benefit under SHBP will be no greater than it would have been if there was no coverage other than that of SHBP. This also applies to state on state coverage. Non-covered services or items, penalties and amounts balance billed are not part of the allowed amount and are the member's responsibility.

It is important that you notify the health insurance vendor you selected if you have other group coverage to prevent incorrect processing of any claims. For further information about COB rules, refer to the SPD or contact your health care vendor directly.

What if I Am Working and Am Eligible for Medicare?

Federal Law requires SHBP to pay primary benefits for active employees and their dependents. Active members or their covered dependents may choose to delay Medicare enrollment. Termination of active employment is a qualifying event for enrolling in Medicare without penalty as our plans are creditable.

Tobacco Surcharge Policy

You should be aware that SHBP charges a Tobacco Surcharge. A $80 Tobacco Surcharge will be added to your monthly premium if you or any of your covered dependents have used tobacco products in the previous 60 days. SHBP provides limited coverage of tobacco cessation medications. To find out how to qualify for coverage of these medications, contact your health care vendor (CIGNA or UHC) for details.

You will automatically be charged the Tobacco Surcharge if you fail to answer the Tobacco question. The surcharge will apply to your premium until the next Plan Year unless you take steps to have the surcharge removed.

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 21 for a complete description of qualifying events or 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.

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 (For all options except the TRICARE Supplement) with HRA incentive fund contributions for their completion of certain required health actions.

The SHBP member and spouse (if covered) are **each** eligible to earn a $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 complete **all** required actions by the dates stated above will each be awarded the $240 HRA incentive fund contribution on January 1, 2014, and may be eligible for additional benefits as determined by SHBP in its sole discretion.

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 health care services are now considered preventive care when properly coded. These services include contraceptive products and services, routine prenatal screenings and breast-feeding equipment and supplies. Contact the vendor's pre-enrollment website, Cigna, at **www.mycigna.com/shbp** and UnitedHealthcare at **www.welcometouhc.com/shbp**.

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. SHBP provides 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**

Understanding
Your Plan Options

Below you will find a brief description of each option offered. CIGNA and United-Healthcare are your health care vendors and each offer an HRA and HDHP option.

NOTE: If you are enrolling in coverage for the first time or if you were not covered by SHBP in 2012, your options are the Standard HRA, Standard HDHP and TRI-CARE Supplement for your first Plan Year. During the next Open Enrollment Period, you may have additional options for the next Plan Year.

Each Plan provides 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 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. HRA dollars reduce the amount you pay towards the deductible and out-of-pocket maximum and can be used to pay any co-insurance you may owe for certain covered services. You pay co-insurance after the deductible is satisfied rather than set dollar co-payments for medical expenses and prescription drugs until the out-of-pocket maximum is met.

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 Standard Plan Option with family coverage, the money funded by SHBP can help cover the first $1,600 of your deductible. This will lower your family deductible of $4,000 to $3,500. 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.

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

- 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
- You will need to file an appeal and select a health care vendor and Option. If the appeal is approved, this change will be retroactive to the beginning of the current Plan Year and you will need to pay the difference in premiums.

Points to Consider if You Elect TRICARE Supplement Plan Coverage

- 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 employees, you could be eligible to enroll your children in PeachCare for Kids if your child(ren) have been without coverage for six months. 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 employees 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 SHBP 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.

Benefits Comparison: HRA—HDHP Plans

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

	Standard HRA Option		Standard HDHP Option	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Covered Services				
Deductible/Co-Payments • You • You + Spouse • You + Child(ren) • You + Family **HRA credits will reduce this amount*	$1,600* $2,800* $2,800* $4,000*		$2,000 $4,000 $4,000 $4,000	$4,000 $8,000 $8,000 $8,000
Out-of-Pocket Maximum • You • You + Spouse • You + Child(ren) • You + Family **HRA credits will reduce this amount*	$4,500* $7,000* $7,000* $9,500*		$4,500 $9,000 $9,000 $9,000	$9,000 $18,000 $18,000 $18,000
HRA Credits • You • You + Spouse • You + Child(ren) • You + Family	$150 $300 $300 $500		None	
Physicians' Services	***The Plan Pays***		***The Plan Pays***	
Primary Care Physician or Specialist Office or Clinic Visits Treatment of illness or injury **Maternity Care** (prenatal, delivery and postpartum)	85% coverage; subject to deductible	60% coverage; subject to deductible	80% coverage; subject to deductible	60% coverage; subject to deductible
Primary Care Physician or Specialist Office or Clinic Visits for the Following: • Wellness care/preventive health care • Annual gynecological exams (these services are not subject to the deductible) • Prenatal care coded as preventative	100% coverage;not subject to deductible	Not covered	100% coverage;not subject to deductible	Not covered
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	80% coverage; subject to deductible	60% coverage; subject to deductible
Physician Services for Emergency Care	85% coverage; subject to deductible		80% coverage; subject to in-network deductible	
Allergy Shots and Serum	85% coverage; subject to deductible	60% coverage; subject to deductible	80% coverage; subject to deductible	60% coverage; subject to deductible

Benefits Comparison: HRA—HDHP Plans

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

	Standard HRA Option		Standard HDHP Option	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Physicians' Services	*The Plan Pays*		*The Plan Pays*	
Outpatient Surgery • When billed as office visit	85% coverage; subject to deductible	60% coverage; subject to deductible	80% 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	80% coverage; subject to deductible	60% coverage; subject to deductible
Hospital Services	*The Plan Pays*		*The Plan Pays*	
Inpatient Services • Inpatient care, delivery and inpatient short-term acute rehabilitation services	85% coverage; subject to deductible	60% coverage; subject to deductible	80% coverage; subject to deductible	60% coverage; subject to deductible
Inpatient Services • Well-newborn care	85% coverage; subject to deductible	60% coverage; subject to deductible	80% coverage; subject to deductible	60% coverage; subject to deductible
Outpatient Surgery Hospital/facility	85% coverage; subject to deductible	60% coverage; subject to deductible	80% 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		80% coverage; subject to in-network deductible	
Outpatient Testing, Lab, etc.	*The Plan Pays*		*The Plan Pays*	
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	80% coverage; subject to deductible	60% coverage; subject to deductible

Benefits Comparison: HRA—HDHP Plans

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

	Standard HRA Option		Standard HDHP Option	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Behavioral Health	*The Plan Pays*		*The Plan Pays*	
Mental Health and Substance Abuse Inpatient Facility and Partial Day Hospitalization	85% coverage; subject to deductible	60% coverage; subject to deductible	80% 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	80% coverage; subject to deductible	60% coverage; subject to deductible
	Contact vendor regarding prior authorization			
Other Coverage	*The Plan Pays*		*The Plan Pays*	
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)	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)
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	80% 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		80% 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	80% 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	

Benefits Comparison: HRA—HDHP Plans

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

	Standard HRA Option		Standard HDHP Option	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Other Coverage	*The Plan Pays*		*The Plan Pays*	
Home Health Care Services NOTE: Prior approval required	85% coverage; subject to deductible	60% coverage; subject to deductible	80% 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	80% 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	80% 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	80% 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	80% coverage; subject to deductible	60% coverage; subject to deductible
Transplant Services NOTE: Prior approval required	Contact vendor for coverage details			

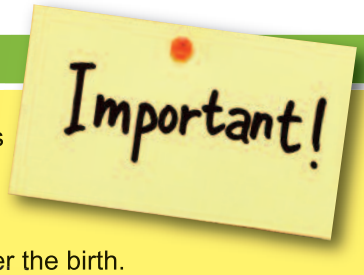
Making Changes When You Have a Qualifying Event

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 days for Medicaid or State Children's Health Insurance Program (SCHIP or Medicare) or 90 days (for a newly eligible dependent child) as 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
- 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.
- You will need to add your newborn within the first of the month of his or her birth. A newborn's charges will not be covered if the effective date occurs the month after the birth. Since SHBP premiums are paid one month in advance of the coverage, retroactive deductions may apply.

IMPORTANT INFORMATION

- 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.

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.dch.georgia.gov/shbp**.

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.

Legal Notices

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 HMO, HRA and HDHP Standard 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

SHBP
State Health Benefit Plan

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

SHBP
State Health Benefit Plan

STATE HEALTH BENEFIT PLAN ANNUAL LEGAL NOTICES

Women's Health and Cancer Rights Act

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

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

Note: Reconstructive surgery requires prior approval, and all inpatient admissions require prior notification. For more detailed information on the mastectomy-related benefits available under the Plan, you can contact the member Services unit for your coverage option. Telephone numbers are on the inside front cover of the Decisions Guide.

Newborns' and Mothers' Health Protection Act

The Plan complies with the Newborns' and Mothers' Protection Act of 1996.
Group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn to less than 48 hours following a vaginal delivery, or les than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother of the newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Health Insurance Portability and Accountability Act

The Plan complies with the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). The HIPAA Privacy Notice is attached as Exhibit A. The Notice of Exemptions Letter is attached as Exhibit B.

Exhibit A

Revised October 1, 2012.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully. Questions? Call 404-656-6322 (Atlanta) or 800-610-1863 (outside of Atlanta).

The DCH and the State Health Benefit Plan Are Committed to Your Privacy. The Georgia Department of Community Health (DCH) sponsors and runs the State Health Benefit Plan (the Plan). We understand that your information is personal and private. Some DCH employees and companies hired by DCH collect your information to run the Plan. The information is called "Protected Health Information" or "PHI." This notice tells how your PHI is used and shared. We follow the information privacy rules of the Health Insurance Portability and Accountability Act of 1996, ("HIPAA").

Only Summary Information is Used When Developing and Changing the Plan. The Board of Community Health and the Commissioner of the DCH make decisions about the Plan. When making decisions, they review reports that explain costs, problems, and needs of the Plan. These reports never include information that identifies any person. If your employer is allowed to leave the Plan entirely, or stop offering the Plan to a portion of its workforce, DHC will provide Summary Health Information (as defined by federal law) for the applicable portion of the workforce. This Summary Health Information does not contain names, dates of birth, or other identifiers, and may only be used by your employer in order to obtain health insurance quotes from other sources and make decision about whether to continue to offer the Plan.

Plan Enrollment Information and Claims Information is Used in Order to Run the Plan. PHI includes two kinds of information. "Enrollment Information" includes 1) your name, address, and Social Security number; 2) your enrollment choices; 3) how much you have paid in premiums; and 4) other insurance you may have. This Enrollment Information is the only kind of PHI your employer is allowed to see. "Claims Information" includes information your health care providers send to the Plan. For example, it may include bills, diagnoses, statements, X-rays or lab test results. It also includes information you send to the Plan. For example, it may include your health questionnaires, enrollment forms, leave forms, letters and recorded telephone calls. Lastly, it includes information about you that is created by the Plan. For example, it includes payment statements and checks to your health care providers.

Your PHI is Protected by Law. Employees of the DCH and employees of outside companies hired by DCH to run the Plan are "Plan Representatives." They must protect your PHI. They may only use it as allowed by HIPAA.

The DCH Must Make Sure the Plan Complies with HIPAA. As Plan sponsor, the DCH must make sure the Plan complies with HIPAA. We must give you this notice. We must follow its terms. We must update it as needed. The DCH is the employer of some Plan Members. The DCH must name the DCH employees who are Plan Representatives. No DCH employee is ever allowed to use PHI for employment decisions.

Plan Representatives Regularly Use and Share your PHI in Order to Pay Claims and Run the Plan. Plan Representatives use and share your PHI for payment purposes and to run the Plan. For example, they make sure you are allowed to be in the Plan. They decide how much the Plan should pay your health care provider. They also use PHI to help set premiums for the Plan and manage costs, but they are never allowed to use genetic information for these purposes. Some Plan Representatives work for outside companies. By law, these companies must protect your PHI. They also must sign "Business Associate" agreements with the Plan. Here are some examples of what they do:

Claims Administrators: Process all medical and drug claims; communicate with Members and their health care providers; and give extra (assistance) to Members with some health conditions.

Data Analysis, Actuarial Companies: Keep health information in computer systems, study it, and create reports from it.

Attorney General's Office, Auditing Companies, Outside Law Firms: Provide legal and auditing help to the Plan.

Information Technology Companies: Help improve and check on the DCH information systems used to run the Plan.

Some Plan Representatives work for the DCH. By law, all employees of the DCH must protect PHI. They also must get special privacy training. They only use the information they need to do their work. Plan Representatives in the SHBP Division work full-time running the Plan. They use and share PHI with each other and with Business Associates in order to help pay claims and run the Plan. In general, they can see your Enrollment Information and the information you give the Plan. A few can see Claims Information. DCH employees outside of the SHBP Division do not see Enrollment Information on a daily basis. They may use Claims Information for payment purposes and to run the Plan.

Plan Representatives May Make Special Uses or Disclosures Permitted by Law. HIPAA has a list of special times when the Plan may use or share your PHI without your authorization. At these times, the Plan must keep track of the use or disclosure.

To Comply with a Law, or to Prevent Serious Threats to Health or Safety: The Plan may use or share your PHI in order to comply with a law, or to prevent a serious threat to health and safety.

For Public Health Activities: The Plan may give PHI to government agencies that perform public health activities.

For Research Purposes: Your PHI may be given to researchers for a research project approved by a review board. The review board must review the research project and its rules to ensure the privacy of your information.

Plan Representatives Share Some Payment Information with the Employee. Except as described in this notice, Plan Representatives are allowed to share your PHI only with you, and with your legal personal representative. However, the Plan may inform the employee family member about whether the Plan paid or denied a claim for another family member.

You May Authorize Other Uses of Your PHI. You may give a written authorization for the Plan to use or share your PHI for a reason not listed in this notice. If you do, you may take away the authorization later by writing to the contact below. The old authorization will not be valid after the date you take it away.

You Have Privacy Rights Related to Plan Enrollment Information and Claims Information that Identifies You.

Right to See and Get a Copy your Information, Right to Ask for a Correction: Except for some reasons listed in HIPAA, you have the right to see and get a copy of information used to make decisions about you. If you think it is incorrect or incomplete, you may ask the Plan to correct it.

Right to Ask for a List of Special Uses and Disclosures: You have the right to ask for a list of special uses and disclosures that were made after April 2003.

Right to Ask for a Restriction of Uses and Disclosures, or for Special Communications: You have the right to ask for added restrictions on uses and disclosures. You also may ask the Plan to communicate with you in a special way.

Right to a Paper Copy of this Notice, Right to File a Complaint without Getting in Trouble: You have the right to a paper copy of this notice. Please contact the SHBP HIPAA Privacy Unit or print it from www.dch.georgia.gov. If you think your privacy rights have been violated, you may file a complaint. You may file the complaint with the Plan and/or the Department of Health and Human Services. You will not get in trouble with the Plan or your employer for filing a complaint.

Addresses for Complaints:
SHBP HIPAA Privacy Unit P.O. Box 1990, Atlanta, Georgia 30301 404-656-6322 (Atlanta) or 800-610-1863 (outside Atlanta)

U.S. Department of Health & Human Services, Office for Civil Rights
Region IV Atlanta Federal Center 61 Forsyth Street SW, Suite 3B70 Atlanta, GA 30303-8909

Exhibit B

Election to be Exempt from Certain Requirements of HIPAA

October 1, 2012

TO: All Members of the State Health Benefit Plan who are not Enrolled in a Medicare Advantage Option

Under a Federal law known as the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Public Law 104-191, as amended, group health plans must comply with a number of requirements. Under HIPAA, state health plans that are "self-funded" may "opt out" of some of these requirements by making a yearly election to be exempt. Your plan option is self-funded because the Department of Community Health pays all claims directly instead of buying a health insurance policy.

Temporary rules implementing the Mental Health Parity and Addiction Equity Act apply January 1, 2013, unless the Department of Community Health again elects to be exempted from this law's requirements. The temporary rules generated more than 4,000 comments; no final rules addressing these comments have been issued. The Department of Community Health has determined to exempt your State Health Benefit Plan ("SHBP") option from the Mental Health Parity and Addiction Equity Act, and the temporary rules' requirements, for the 2013 calendar year.

> Parity in the application of certain limits to mental health benefits. Group health plans (of employers that employ more than 50 employees) that provide both medical and surgical benefits and mental health or substance use disorder benefits must ensure that financial requirements and treatment limitations applicable to mental health or substance use disorder benefits are no more restrictive than the predominant financial requirements and treatment limitations applicable to substantially all medical and surgical benefits covered by the plan.

The exemption from these federal requirements will be in effect for the plan year starting January 1, 2013, and ending December 31, 2013. The election may be renewed for subsequent plan years.

HIPAA also requires the SHBP to provide covered employees and dependents with a "certificate of creditable coverage" when they cease to be covered under the SHBP. There is no exemption from this requirement. The certificate provides evidence that you were covered under the SHBP, because if you can establish your prior coverage, you may be entitled to certain rights to reduce or eliminate a preexisting condition exclusion if you join another employer's health plan, or if you wish to purchase an individual health insurance policy.

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.

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.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State Health Benefit Plan