State Health Benefit Plan –– Standard High Deductible Health Plan Option

OPEN ACCESS PLUS MEDICAL BENEFITS

EFFECTIVE DATE: January 1, 2012

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This document printed in July, 2012 takes the place of any documents previously issued to you which described your benefits.

Printed in U.S.A.

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Important Information

THIS IS NOT AN INSURED BENEFIT PLAN. THE BENEFITS DESCRIBED IN THIS BOOKLET OR ANY RIDER ATTACHED HERETO ARE SELF-INSURED BY STATE HEALTH BENEFIT PLAN WHICH IS RESPONSIBLE FOR THEIR PAYMENT. CIGNA HEALTH AND LIFE INSURANCE COMPANY (CIGNA) PROVIDES CLAIM ADMINISTRATION SERVICES TO THE PLAN, BUT CIGNA DOES NOT INSURE THE BENEFITS DESCRIBED.

THIS DOCUMENT MAY USE WORDS THAT DESCRIBE A PLAN INSURED BY CIGNA. BECAUSE THE PLAN IS NOT INSURED BY CIGNA, ALL REFERENCES TO INSURANCE SHALL BE READ TO INDICATE THAT THE PLAN IS SELF-INSURED.

HC-NOT1

Introduction

This booklet is your Summary Plan Description (SPD) and describes the provisions of State Health Benefit Plan and this High Deductible Plan Option under the State Health Benefit Plan. This High Deductible Standard Plan Option is referred to in this booklet as the "HDHP Option," and the State Health Benefit Plan is referred to as the "SHBP" or "the Plan." You have this SPD because you are enrolled in the HDHP Option under the SHBP. Use this SPD as a reference tool to help you understand the Plan and maximize your coverage.

The SHBP consists of three plans established by Georgia law: a plan for State employees, a plan for public school teachers, and a plan for public school employees other than teachers. The SHBP is self insured, and is governed by certain Georgia laws, the regulations of the Department of Community Health (DCH), Chapter 111-4-1 Health Benefit Plan, and resolutions of the Board of Community Health that establish required contributions that must be paid to the SHBP. If there are discrepancies between the information in this SPD and DCH regulations or the laws of the state of Georgia, or the Board resolutions setting required contributions, those regulations, laws and resolutions will govern at all times.

This booklet is notice to all Covered Persons of the Plan's eligibility requirements and benefits payable under the HDHP Option for services provided on or after January 1, 2012, unless otherwise noted. Any and all statements to Covered Persons or to providers about eligibility, payment or levels of payment that were made before January 1, 2012 are canceled if they conflict in any way with the provisions described in this booklet.

The Department of Community Health is the Plan Administrator, and reserves the right to act as sole interpreter of all the terms and conditions of the Plan, except where expressly delegated to the Claims Administrator. The Plan Administrator has delegated full responsibility for claims administration to CIGNA, the Claims Administrator for the Plan. The Claims Administrator processes and pays claims in accordance with the terms of the Plan, this booklet and the separate medical policy guidelines that serve as supplement to this booklet to more fully define eligible charges. The Claims Administrator has the discretion to interpret the terms of the Plan when processing and paying claims and makes final decisions with respect to medical and pharmacy claims.

The Department of Community Health also reserves the right to modify the benefits, level of benefit coverage and eligibility/participation requirements for the Plan at any time, subject only to reasonable notification to Members. When such a change is made, it will apply as of the modification's effective date to any and all charges incurred by Members on that day and after, unless otherwise specified by the DCH.

How to Use this Document

We encourage you to read your SPD.

We especially encourage you to review the benefit limitations of this SPD by reading **The Schedule** and **Exclusions**. You should also carefully read the section titled **Legal Notices – Department of Community Health** and **CIGNA Federal Other General Legal Requirements** to better understand how this SPD and your benefits work. You should call CIGNA if you have questions about the limits of the coverage available to you.

Many of the sections of the SPD are related to other sections of the document. You may not have all of the information you need by reading just one section. We also encourage you to keep your SPD and any attachments in a safe place for your future reference.

Please be aware that your Physician does not have a copy of your SPD and is not responsible for knowing or communicating your benefits.

Information about Defined Terms

Because this SPD is a legal document, we want to give you information about the document that will help you understand it. Certain capitalized words have special meanings. We have defined these words in the section

titled **Definitions**. You can refer to the **Definitions** section as you read this document to have a clearer understanding of your SPD.

When we use the words "we", "us", and "our" in this document, we are referring to the Department of Community Health, SHBP Division. When we use the words "you" and "your" we are referring to people who are Covered Persons.

Fraud and Abuse

Please notify the Plan of any fraudulent activity regarding Plan Members, providers, payment of benefits, etc. Call 1-800-633-8519.

Your Contribution Requirements

All Members are required to make regular contributions (called premiums) in order to maintain coverage. All contributions by active employees must be made through salary deductions. Contributions by former employees must be made through annuity deductions, if possible, or through direct payments. The Board of Community Health sets the contribution requirements by resolution. Usually the contribution requirements are set on an annual basis before Open Enrollment and the Retiree Option Change Period, but contributions may be changed by the Board at any time, subject to advance notice. It is the Member's responsibility to make sure that the contributions paid are appropriate for the plan option selected. Contact your benefits representative for information about the required contributions you are responsible for paying.

Customer Service and Claims Submittal

Please make note of the following information that contains CIGNA department names and telephone numbers.

Customer Service Representative (questions regarding Coverage or procedures):

Active Members 1-800-633-8519
Retiree Members 1-800-942-6724
Monday – Friday: 8:00 a.m. – 8:00 p.m.

Pre-Admission Certification:

Active Members 1-800-633-8519
Retiree Members 1-800-942-6724
For detailed explanation on Pre-Admission Certification/Continued Stay Review please see page 36.

Mental Health/Substance Abuse Services:

Active Members 1-800-633-8519
Retiree Members 1-800-942-6724

Pharmacy Services:

Active Members 1-800-633-8519
Retiree Members 1-800-942-6724

Written appeals and inquiries related to Medical claims should be directed to:

CIGNA Appeals Unit
P. O. Box 188011
Chattanooga, TN 37422

Written appeals and inquiries related to the Prescription Drug Program should be directed to:

CIGNA
P.O. Box 188050
Chattanooga, TN 37422-8050

CIGNA Vision Services:

CIGNA Vision Claims Department
P.O. Box 997561
Sacramento, CA 95899-7561

Plan's Eligibility Unit:

800-610-1863, toll-free
Monday-Friday: 8:30 a.m. to 4:30 p.m.

Membership Correspondence and Appeals for eligibility issues and issues other than medical or pharmacy claims:

State Health Benefit Plan
Membership Correspondence Unit
P. O. Box 1990
Atlanta, GA 30301-1990

Note: For forms and procedures go to www.dch.georgia.gov/shbp.

Note: SHBP handles all eligibility appeals. All Member correspondence sent to the Plan (including SHBP forms and Medicare Part D ID card copies) should include the Member's Social Security Number (SSN) to prevent a delay in processing your requests.

Explanation of Terms

You will find terms starting with capital letters throughout your certificate. To help you understand your benefits, most of these terms are defined in the Definitions section of your certificate.

The Schedule

The Schedule is a brief outline of your maximum benefits which may be payable under your insurance. For a full description of each benefit, refer to the appropriate section listed in the Table of Contents.

Special Plan Provisions

Participating Providers include Physicians, Hospitals and Other Health Care Professionals and Other Health Care Facilities. Consult your Physician Guide for a list of Participating Providers in your area. Participating Providers are committed to providing you and your Dependents appropriate care while lowering medical costs. It is recommended that you verify that your physician is still a Participating Provider prior to each office visit.

Services Available in Conjunction With Your Medical Plan

The following pages describe helpful services available in conjunction with your medical plan. You can access these services by calling the toll-free number shown on the back of your ID card.

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CIGNA'S Toll-Free Care Line

CIGNA's toll-free care line allows you to talk to a health care professional during normal business hours, Monday through Friday (Eastern Time Zone), simply by calling the toll-free number shown on your ID card.

CIGNA's toll-free care line personnel can provide you with the names of Participating Providers. If you or your Dependents need medical care, you may consult your Physician Guide which is available on-line at myCIGNA.com and lists the Participating Providers in your area or call CIGNA's toll-free number for assistance. If you or your Dependents need medical care while away from home, you may have access to a national network of Participating Providers through CIGNA's Away-From-Home Care feature. Call CIGNA's toll-free care line for the names of Participating Providers in other network areas. Whether you obtain the name of a Participating Provider from your Physician Guide or through the care line, it is recommended that prior to making an appointment you call the provider to confirm that he or she is a current participant in the Open Access Plus Program.

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Case Management

Case Management is a service provided through a Review Organization, which assists individuals with treatment needs that extend beyond the acute care setting. The goal of Case Management is to ensure that patients receive appropriate care in the most effective setting possible whether at home, as an outpatient, or an inpatient in a Hospital or specialized facility. Should the need for Case Management arise, a Case Management professional will work closely with the patient, his or her family and the attending Physician to determine appropriate treatment options which will best meet the patient's needs and keep costs manageable. The Case Manager will help coordinate the treatment program and arrange for necessary resources. Case Managers are also available to answer questions and provide ongoing support for the family in times of medical crisis.

Case Managers are Registered Nurses (RNs) and other credentialed health care professionals, each trained in a clinical specialty area such as trauma, high risk pregnancy and neonates, oncology, mental health, rehabilitation or general medicine and surgery. A Case Manager trained in the appropriate clinical specialty area will be assigned to you or your Dependent. In addition, Case Managers are supported by a panel of Physician advisors who offer guidance on up-to-date treatment programs and medical technology. While the Case Manager recommends alternate treatment programs and helps coordinate needed resources, the patient's attending Physician remains responsible for the actual medical care.

1. You, your dependent or an attending Physician can request Case Management services by calling the toll-free number shown on your ID card during normal business hours, Monday through Friday (Eastern Time Zone). In addition, a claim office or a utilization review program (see the PAC/CSR section of your certificate) may refer an individual for Case Management.

2. The Review Organization assesses each case to determine whether Case Management is appropriate.
3. You or your Dependent is contacted by an assigned Case Manager who explains in detail how the program works. Participation in the program is voluntary - no penalty or benefit reduction is imposed if you do not wish to participate in Case Management.

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4. Following an initial assessment, the Case Manager works with you, your family and Physician to determine the needs of the patient and to identify what alternate treatment programs are available (for example, in-home medical care in lieu of an extended Hospital convalescence). You are not penalized if the alternate treatment program is not followed.
5. The Case Manager arranges for alternate treatment services and supplies, as needed (for example, nursing services or a Hospital bed and other Durable Medical Equipment for the home).
6. The Case Manager also acts as a liaison between the insurer, the patient, his or her family and Physician as needed (for example, by helping you to understand a complex medical diagnosis or treatment plan).
7. Once the alternate treatment program is in place, the Case Manager continues to manage the case to ensure the treatment program remains appropriate to the patient's needs.

While participation in Case Management is strictly voluntary, Case Management professionals can offer quality, cost-effective treatment alternatives, as well as provide assistance in obtaining needed medical resources and ongoing family support in a time of need.

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Additional Programs

We may, from time to time, offer or arrange for various entities to offer discounts, benefits, or other consideration to our Members for the purpose of promoting the general health and well being of our Members. We may also arrange for the reimbursement of all or a portion of the cost of services provided by other parties to the Policyholder. Contact us for details regarding any such arrangements.

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Well Aware Programs

Your benefit plan includes several programs to assist you with managing your healthcare and specifically for managing the following chronic conditions:

- Asthma;
- Low Back Pain;
- Cardiovascular Disease;
- Chronic Obstructive Pulmonary Disorder;
- Diabetes; and
- Depression.

Nurse Advice Line

You may call for professional medical advice regarding medical situations 24 hours a day, seven days a week. By calling this number, you can talk with a nurse who will assist you in making informed decisions about your health. For medical information and nurse assistance dial:

For Active Employees: 1- 800-633-8519; or
For Retired Employees: 1-800-942-6724.

Important Information About Your Medical Plan

Patient Protection and Affordable Care Act Endorsement

The group contract or certificate is amended as stated below.

In the event of a conflict between the provisions of your plan documents and the provisions of this endorsement, the provisions that provide the better benefit shall apply.

Definitions

"Emergency medical condition" means a medical condition which manifests itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in 1) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; 2) serious impairment to bodily functions; or 3) serious dysfunction of any bodily organ or part.

"Emergency services" means, with respect to an emergency medical condition: (a) a medical screening examination that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate the emergency medical condition; and (b) such further medical examination and treatment, to the extent they are within the capabilities of the staff and facilities available at the hospital, to stabilize the patient.

"Essential health benefits" means, to the extent covered under the plan, expenses incurred with respect to covered services, in at least the following categories: ambulatory patient services, emergency services, hospitalization, maternity and newborn care, mental health and substance use disorder services, including behavioral health treatment, prescription drugs, rehabilitative and habilitative services and devices, laboratory services, preventive and wellness services and chronic disease management and pediatric services, including oral and vision care.

"Patient Protection and Affordable Care Act of 2010" means the Patient Protection and Affordable Care Act of 2010 (Public Law 111-148) as amended by the Health Care and Education Reconciliation Act of 2010 (Public Law 111-152).

"Stabilize" means, with respect to an emergency medical condition, to provide such medical treatment of the condition as may be necessary to assure, within reasonable medical probability that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility.

Lifetime Dollar Limits

Any lifetime limit on the aggregate dollar value of essential health benefits is deleted. Any lifetime limits on the dollar value of any essential health benefits are deleted.

Annual Dollar Limits

Any annual limits on the dollar value of essential health benefits are deleted.

Rescissions

Your coverage may not be rescinded (retroactively terminated) unless: (1) the plan sponsor or an individual (or a person seeking coverage on behalf of the individual) performs an act, practice or omission that constitutes fraud; or (2) the plan sponsor or individual (or a person seeking coverage on behalf of the individual) makes an intentional misrepresentation of material fact; or (3) premiums not received.

Extension of Coverage to Dependents

Dependent children are eligible for coverage up to the age of 26. Any restrictions in the definition of Dependent in your plan document which require a child to be unmarried, a student, financially dependent on the employee, etc. no longer apply. If the definition of Dependent in the plan document provides coverage for a child beyond

age 26, the provision and all restrictions will continue to apply starting at age 26. Any provisions related to coverage of a handicapped child continue to apply starting at age 26.

Preventive Services

In addition to any other preventive care services described in the plan documents, no deductible, copayment, or coinsurance shall apply to the following Covered Services.

However, the covered services must be provided by a Participating Provider and the claim must be submitted with a valid preventive code:

(1) evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force;

(2) immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the Covered Person involved;

(3) for infants, children, and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration;

(4) for women, such additional preventive care and screenings not described in paragraph (1) as provided for in comprehensive guidelines supported by the Health Resources and Services Administration.

Preservice Medical Necessity Determinations

If standard determination periods would (a) seriously jeopardize your life or health, your ability to regain maximum function, or (b) in the opinion of a Physician with knowledge of your health condition, cause you severe pain which cannot be managed without the requested services, the preservice determination will be made on an expedited basis. The Physician reviewer, in consultation with the treating Physician, will decide if an expedited determination is necessary. You or your representative will be notified of an expedited determination within 72 hours after receipt of the request.

Notice of Adverse Determination

In addition to the description provided in your plan documents, a notice of adverse benefit determination will also include information sufficient for you to identify the claim, and information about any office of health insurance consumer assistance or ombudsman available to assist you with the appeal process. In the case of a final adverse benefit determination, your notice will include a discussion of the decision.

Right to Appeal

You have the right to appeal any decision or action taken to deny, reduce, or terminate the provision of or payment for health care services covered by your plan or to rescind your coverage. When a requested service or payment for the service has been denied, reduced or terminated based on a judgment as to the medical necessity, appropriateness, health care setting, level of care, or effectiveness of the health care service, you have the right to have the decision reviewed by an independent review organization not associated with CIGNA.

Except where life or health would be seriously jeopardized, you must first exhaust the internal appeal process set forth in your plan documents before your request for an external independent review will be granted. If the plan does not strictly adhere to all internal claim and appeals processes, you can be deemed to have exhausted the internal appeal process.

Your appeal rights are outlined in your plan documents. In addition, before a final internal adverse benefit determination is issued, if applicable, you will be provided, free of charge, any new or additional evidence considered, or rationale relied upon, in sufficient time to allow you the opportunity to respond before the final notice is issued.

Emergency Services

Emergency Services, as defined above, are covered without the need for any prior authorization determination and without regard as to whether the health care provider furnishing such services is a participating provider.

Emergency Services, as defined above, provided by a Non-participating Provider will be covered as if the services were provided by a Participating Provider.

Direct Access to Obstetricians and Gynecologists

You do not need prior authorization from the plan or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, visit www.myCIGNA.com or contact customer service at the phone number listed on the back of your ID card.

Selection of a Primary Care Provider

This plan generally allows the designation of a primary care provider. You have the right to designate any primary care provider who participates in the network and who is available to accept you or your family members. Until you make this designation, CIGNA designates one for you. For information on how to select a primary care provider, and for a list of the participating primary care providers, visit www.myCIGNA.com or contact customer service at the phone number listed on the back of your ID card.

For children, you may designate a pediatrician as the primary care provider.

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How To File Your Claim

There's no paperwork for In-Network care. Just show your identification card and pay your share of the cost, if any; your provider will submit a claim to CIGNA for reimbursement. Out-of-Network claims can be submitted by the provider if the provider is able and willing to file on your behalf. If the provider is not submitting on your behalf, you must send your completed claim form and itemized bills to the claims address listed on the claim form. You may get the required claim forms from the website listed on your identification card or by calling Member Services using the toll-free number on your identification card.

How To File Your Out-of-Network Claim

The prompt filing of any required claim form will result in faster payment of your claim. All claims should be filed within 24 months from the date services are rendered.

You may get the required claim forms by visiting myCIGNA.com. All fully completed claim forms and bills should be sent directly to:

CIGNA
P.O. Box 188050
Chattanooga, TN 37422-8050

Depending on your Group Insurance Plan benefits, file your claim forms as described below.

Hospital Confinement

If possible, get your Group Medical Insurance claim form before you are admitted to the Hospital. This form will make your admission easier and any cash deposit usually required will be waived.

If you have a benefit Identification Card, present it at the admission office at the time of your admission. The card tells the Hospital to send its bills directly to CIGNA.

Doctor's Bills and Other Medical Expenses

The first Medical Claim should be filed as soon as you have incurred covered expenses. Itemized copies of your bills should be sent with the claim form. If you have any additional bills after the first treatment, file them promptly.

CLAIM REMINDERS

- BE SURE TO USE YOUR MEMBER ID AND ACCOUNT NUMBER WHEN YOU FILE CIGNA'S CLAIM FORMS, OR WHEN YOU CALL YOUR CIGNA CLAIM OFFICE.

  YOUR MEMBER ID IS THE ID SHOWN ON YOUR BENEFIT IDENTIFICATION CARD.

  YOUR ACCOUNT NUMBER IS THE 7-DIGIT POLICY NUMBER SHOWN ON YOUR BENEFIT IDENTIFICATION CARD.
- PROMPT FILING OF ANY REQUIRED CLAIM FORMS RESULTS IN FASTER PAYMENT OF YOUR CLAIMS.

WARNING: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit is guilty of a crime and may be subject to fines and confinement in prison.

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Eligibility — Effective Date

Who is Eligible for Coverage

Who	Description	Who Determines Eligibility
Eligible Person	Complete eligibility rules are set forth in SHBP statutes and regulations, and the rules in the statutes and regulations control if there is a conflict with this summary. Although currently operated as one plan, there are actually three plans that make up the SHBP: a plan for State employees described in O.C.G.A. Section 45-18-1, a plan for public school teachers described in O.C.G.A. Section 20-2-881, and a plan for public school service personnel other than teachers described in O.C.G.A. Section 20-2-911. **Eligibility rules for the plan for State employees.** "Regular full-time" means you are scheduled to work at least 30 hours a week and you work at least 30 hours a week consistently. "Full-time" employee means you are classified by your employer as a full-time employee. "Part-time" employee means you are classified by your employer as a part-time employee. Not Eligible: individuals classified by the employer as temporary (expected to work less than nine months), seasonal, intermittent workers or independent contractors. In general, you are eligible to enroll yourself and your eligible dependents for coverage if you meet one of the descriptions below. A regular full-time employee of a department, board, agency or commission, General Assembly, or community service board of the State of Georgia, A part-time employee of the General Assembly who had coverage prior to January 1981 or an administrative or clerical employee of the General Assembly, A full-time district attorney, assistant district attorney or a district attorney's investigator of the superior courts appointed pursuant to O.C.G.A. Section 15-18-14, A full-time secretary or law clerk employed by district attorneys and judges and employed under O.C.G.A. Sections 15-18-17-19, A regular full-time employee who receives salary or wage payment from a county board of health or county board of family and children services, A member of the General Assembly,	The Plan Administrator determines who is eligible to enroll under the Plan.

Who	Description	Who Determines Eligibility
	A regular full-time employee of a State authority that participates in the Employees' Retirement System and participates in the Plan by paying all required contributions to the Plan, A regular full-time employee of an entity that offers the Plan to its employees pursuant to a current contract with the Department of Community Health. In some cases, employees described above may continue SHBP coverage after resignation with 8 or more Years of Service or retirement with an annuity. (See Provisions for Eligible Annuitants, Eligible Former Employees & Those Considering Retirement or Resignation after 8 Years of Service Section details on page 89.) Employees who terminate employment with less than 8 Years of Service may be able to continue SHBP coverage through COBRA. (See Provisions for Eligible Annuitants, Eligible Former Employees & Those Considering Retirement or Resignation after 8 Years of Service Section details on page 89.) **Eligibility rules for the plan for public school teachers.** Teachers who are employed not less than half time, which must be at least seventeen and a half (17½) hours per week, in the public school systems of Georgia are eligible to participate. An eligible teacher shall not include any independent contractor, emergency or temporary worker, or person employed by a charter school that has not elected to offer SHBP coverage, or that has revoked SHBP coverage. Eligible teachers must be employed not less than half time, which must be at least seventeen and a half (17½) hours per week, and are further defined as: A person employed in a professionally certificated capacity or position in the public school systems of Georgia; A person compensated in a professionally certificated capacity or position in a charter school that has elected to offer SHBP coverage and has not revoked SHBP coverage; A person employed by a regional or county library of Georgia; A person employed in a professionally certificated capacity or position in the public vocational and technical schools operated by a local school system; A person employed in a professionally certificated capacity or position in the Regional Educational Service Areas of Georgia; A person employed in a professionally certificated capacity or position in the high school program of the Georgia Military College.	

Who	Description	Who Determines Eligibility
	In some cases, employees described above may continue SHBP coverage after resignation with 8 or more Years of Service or retirement with an annuity. (See Provisions for Eligible Annuitants, Eligible Former Employees & Those Considering Retirement or Resignation after 8 Years of Service Section details on page 89.) Employees who terminate employment with less than 8 Years of Service may be able to continue SHBP coverage through COBRA. (See Provisions for Eligible Annuitants, Eligible Former Employees & Those Considering Retirement or Resignation after 8 Years of Service Section details on page 89.) **Eligibility rules for the plan for other public school employees.** Any person who is not eligible under the rules above for the plan for public school teachers, who is employed by a local school system that has not withdrawn from the plan for public school employees in accordance with requirements of the DCH, or who is employed by a charter school that has elected to offer SHBP coverage and has not revoked SHBP coverage, and who meets the following work requirements: If you are eligible to participate in the Teachers Retirement System or its local equivalent, you must work at least 60% of a standard schedule for the position, as determined by the employer, but not less than 20 hours a week, and you may not be classified by your employer as an independent contractor or emergency or temporary worker. If you are eligible for the Public School Employees' Retirement System, you must work at least 60% of the standard schedule for your position, but not less than 15 hours a week, and not be employed as an independent contractor or on an emergency or temporary basis. If you are an employee of a charter school who is not working in a certificated position or capacity, you must work at least half-time, and not be employed as an independent contractor or on an emergency or temporary basis. In some cases, employees described above may continue SHBP coverage after resignation with 8 or more Years of Service or retirement with an annuity. (See Provisions for Eligible Annuitants, Eligible Former Employees & Those Considering Retirement or Resignation after 8 Years of Service Section details on page 89.) Employees who terminate employment with less than 8 Years of Service may be able to continue SHBP coverage through COBRA. (See Provisions	

Who	Description	Who Determines Eligibility
	for Eligible Annuitants, Eligible Former Employees & Those Considering Retirement or Resignation after 8 Years of Service Section details on page 89.)	

Who	Description	Who Determines Eligibility
	Eligible dependents are: • **Your legally married spouse; as defined by Georgia law.** • **Your dependent children who are:** 1. **Natural or legally adopted children or stepchildren under age 26**. Natural Child – child for which 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 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 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 26 or at the end of the month in which he or she loses status as a step child of the enrolled member, whichever date is earlier. 2. **Other children under 26.** A dependent child for whom the enrolled member is legal guardian. Eligibility begins on the date legal guardianship is established and ends at the end of the month in which the child reaches age 26 or at the end of the month in which legal guardianship terminates, whichever is earlier. 3. **Your natural children, legally adopted children or stepchildren who are disabled prior to age 26 from categories 1 and 2** above who are physically or mentally disabled prior to age 26, and are primarily dependent on the enrolled member for support and maintenance. You will be required to provide copies of certified documents such as a marriage license, birth certificate, adoption contract or judge-signed court order to verify your dependent relationship and the Social Security number. **Note: Coverage will not be updated until verification is approved. The Plan has the right to determine whether or not the documentation satisfies Plan requirements.**	The Plan Administrator determines who qualifies as a Dependent.

Who	Description	Who Determines Eligibility
Dependent	**For a Covered Dependent age 26 & older…** • … and disabled before age 26: You must: • file a written request for continuation of coverage within 31 days of the 26th birthday to continue coverage. • when requested by the Plan, you must re-certify your dependent(s). If you fail to re-certify your dependent within 31 days of the request, your dependent will no longer be eligible to be covered under the Plan until verification is received. If documentation is received after 31 days, the plan will cover the dependent retroactively to the beginning of the current plan year or date of qualifying event, whichever is later, as long as the correct tier premium is paid. **To enroll a disabled child as a new dependent (must be disabled prior to age 26), you must:** • make a request within 31 days of your hire date or qualifying event date OR add the child during the Active Open Enrollment period; and • provide medical documentation that must be approved by the Plan.	The Plan Administrator determines who qualifies as a Dependent.
A general note regarding documentation sent to the Plan: While the Plan requires that coverage requests are made within a specific time period, the documentation required to support the request may be filed later if necessary within the 31 days following the deadline to file the request. When SHBP requests documentation, if the documentation is not received within 31 days of the SHBP request, the effective date of the coverage change will be the later of the qualifying event date or first day of the plan year.		

Qualified Medical Child Support Orders

If a QMCSO requires:	You can:
You to provide coverage for your natural child(ren)	• Enroll or change coverage tier – there is no time limit for this change; documentation of the court order and the other coverage is required. You must also provide the Social Security Number for each dependent you wish to cover.
Your former spouse to provide coverage for each of your enrolled natural child(ren)	• Change coverage tier. Documentation of the court order and the other coverage is required.

Who's Not Eligible for Dependent Coverage

The most common examples of persons not eligible for SHBP dependent coverage include:

- Your former spouse.
- Your fiancé.
- Your parents.
- Children age 26 or older who do not qualify as disabled dependents.
- Grandchildren who cannot be considered eligible dependents..
- Anyone living in your home that is not related by marriage or birth, unless otherwise noted.

NOTE: If you misrepresent eligibility information when applying for coverage, during a change in coverage or when filing for benefits, or by paying for coverage on behalf of someone who is not eligible, adverse action may be taken against you by DCH or applicable enforcement agencies. Adverse actions include, but are not limited to: terminating your coverage, collection actions for all payments improperly made as a result of the misrepresentation, and criminal prosecution.

When to Enroll and When Coverage Begins

You *must* enroll to have SHBP coverage. To enroll, go to your personnel/payroll office for instructions. You will be asked to:

Choose a coverage option; *

Choose a coverage tier; and

Provide the name(s) of eligible dependents you want to enroll and cover.

*If newly enrolling in the plan because you are a new employee, because of Open Enrollment or a qualifying event, your plan options are restricted to the standard consumer driven health plan options.

Enrollment authorizes periodic payroll deductions for premiums. If you list dependent(s) you must elect a coverage tier that covers the dependent(s) by relationship to you. If you cover dependents and do not provide documentation to verify eligibility, you will be charged the tier you elected. Once dependents are verified the coverage will be effective from the date of the qualifying event or the 1st day of the current plan year, whichever is later. Please refer to "Who is eligible for coverage" for more information. Once you make your coverage election, changes are not allowed outside the Open Enrollment period, unless you have a qualified change in status under Section 125 of the Internal Revenue Code, which restricts changes in the SHBP outside the annual open enrollment period.

Special Note: 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, provided you are eligible for that option and have not had a qualifying event since coverage ended.

If You Are Hospitalized When Your Coverage Begins

If you are inpatient in a Hospital, Skilled Nursing Facility or Inpatient Rehabilitation Facility on the day your coverage begins, SHBP will pay benefits for Covered Health Services related to that Inpatient Stay from the effective date of coverage as long as you receive Covered Health Services in accordance with the terms of the Plan. You should notify CIGNA within 48 hours of the day your coverage begins, or as soon as reasonably possible. In-Network benefits are available only if you receive Covered Health Services from Contracted providers.

Important Plan Membership Terms

This SPD uses these terms to describe Plan Membership:

Member – You, the contract/policyholder.

Dependent – your eligible dependents that you choose to enroll.

Where appropriate, this SPD relies on these terms throughout the document:

You, Employee, Retiree or Member… to refer to Member.

Dependent(s)… to refer to Dependents, Spouse and Children

DCH Surcharge Policy

Spousal Surcharge:

A spousal surcharge of $50 is added to your monthly premium if you failed to answer spousal surcharge questions during your Initial Enrollment, Open Enrollment or the Retiree Option Change Period, or you answered that you elect to cover your spouse and your spouse is eligible for coverage other than SHBP coverage through his/her employment but chose not to take it. The spousal surcharge can be removed in certain circumstances by completing the spousal surcharge affidavit and attaching the required documents. Details can be found on the Department of Community Health Web site, www.dch.georgia.gov/shbp. You are required to pay the spousal surcharge for all months in which your enrolled spouse is eligible for coverage other than SHBP coverage and is not enrolled in the other coverage. It is your responsibility to notify DCH, SHBP Division, immediately if your answers to the spousal surcharge questions change during the year. If you received a waiver of the spousal surcharge based on your answers and you fail to notify DCH, SHBP Division of an event that makes you ineligible for the waiver (such as your spouse dropping other health coverage for which he or she is eligible), this may be viewed as an intentional misrepresentation.

Tobacco Surcharge:

A tobacco surcharge of $80 is added to your monthly premium if you failed to answer tobacco surcharge questions during your Initial Enrollment, Open Enrollment or the Retiree Option Change Period or if you answered that a covered member of your family used tobacco products in the previous sixty days. The tobacco surcharge may be removed by following the tobacco surcharge removal procedures found on the Department of Community Health Website, www.dch.georgia.gov/shbp. You are required to pay the tobacco surcharge for all months in which you or any of your enrolled family members use tobacco. Therefore, it is your responsibility to notify DCH, SHBP Division immediately if your answers to the tobacco surcharge questions change during the year. If you received a waiver of the tobacco surcharge based on your answers

and you fail to notify DCH, SHBP Division that you or a member of your enrolled family members begins using tobacco, this may be viewed as an intentional misrepresentation.

Intentional misrepresentation in response to surcharge questions or failure to notify DCH, SHBP Division of changes to your responses to surcharge will have significant consequences. Active employees will lose State Health Benefit Plan coverage for 12 months beginning on the date that your false response or failure to notify is discovered. Retirees who intentionally misrepresent the response to the surcharge questions or fail to notify DCH, SHBP Division of changes to their responses will permanently lose their SHBP health insurance.

When to Enroll, Plan Options and When Coverage Begins

When to Enroll:	Who Can Enroll:	Enrollment Information:
Initial Enrollment Period The Initial Enrollment Period is the first period of time when Eligible Persons can enroll.	Eligible Employees may enroll themselves and their Dependents.	Enrollment must be completed within 31 days of your date of hire.
Open Enrollment Period	Open Enrollment occurs every fall for the following plan year. Eligible Persons may enroll themselves and their Dependents. Any Dependent(s) removed during the Open Enrollment period are not eligible for COBRA. However, if a dependent spouse is removed during the Open Enrollment period because of anticipated divorce, the former dependent spouse may elect COBRA once the divorce is finalized.	The Plan Administrator determines the Open Enrollment Period. Coverage begins on January 1st of the following Plan year.

If you are:	You can enroll or make changes:	Your coverage takes effect:
• A current employee	• Make coverage changes during Open Enrollment. • Make coverage changes within 31 days of a qualifying event (90 days for a newborn)	• The upcoming January 1st. • First of the month following request.
• A newly hired employee	• Enroll in a Standard consumer driven health plan option (the Standard Health Reimbursement Arrangement or Standard High Deductible Health Plan) within 31 days of your hire date.	• First of the month after a full calendar month of employment.

Plan Options

If you are:	
• A current employee	• If newly enrolling in the health plan because of open enrollment or a qualifying event, your plan options are restricted to the standard consumer driven health plan options: the Standard Health Reimbursement Arrangement (HRA) and Standard High Deductible Health Plan (HDHP) for the first plan year. Once enrolled, you may elect any available health plan option during the following Open Enrollment.
• A newly hired employee	• Plan options are restricted to the standard consumer driven health plan options: the Standard Health Reimbursement Arrangement (HRA) and Standard High Deductible Health Plan (HDHP) for the first plan year. Once enrolled, you may elect any available health plan option during the following Open Enrollment.
• If you terminate employment and are rehired by any employer offering SHBP coverage	• If the rehire occurs within the same plan year, you must retain the same SHBP option you had, even if there is a gap in coverage. • If the termination of employment is in one year and you are re-hired in the following year, with a gap in coverage, then you are restricted to the standard consumer driven health plan options: the Standard Health Reimbursement Arrangement (HRA) and Standard High Deductible Health Plan (HDHP) with the new employer. Once enrolled, you may elect other health plan options during the following Open Enrollment. If there is no gap in coverage, then you may elect any available health plan option.

When Coverage Begins for You

When your coverage starts depends on when you enroll and when you make requests that affect your coverage.

	When you Enroll	Coverage Takes Effect
Transferring Employees	If you are transferring between participating employers that offer SHBP coverage: • Contact your new employer to coordinate continuous coverage • You must continue the same coverage, unless you had a qualifying event that allows a change in coverage	• There is no coverage lapse when your employment break is less than one calendar month and your new employer deducts the premium from your first paycheck. • If there is a break in employment with employers that offer SHBP coverage that is longer than one calendar month, the coverage begins on the first day of the month following one full month of employment.
For You	• During an open enrollment period • As a new employee • When you are reinstated or return to work from an unpaid leave of absence that occurred during an open enrollment period • When you have a qualifying event	• On January 1st of the new Plan year • On the first day of the month following one full calendar month of employment • On the first day of the month following the return or, if a judicial reinstatement, on the day specified in the settlement agreement • On the first day of the month following the request
For Your Dependents	As a new employee, dependent coverage begins when your coverage begins. If you add dependents due to a qualifying event, coverage takes place as described in the following section.	

When Coverage Begins when you experience a Qualifying Event

You may pick up coverage or add dependents if you experience a qualifying event. Coverage takes effect as described in the chart below. If you are currently enrolled in a Standard Plan or you are enrolling for the first time or enrolling due to a qualifying event your options are limited to the Standard HRA and Standard HDHP options.

The Centers for Medicare & Medicaid Services (CMS) regulations now require the DCH, SHBP Division to collect the Social Security Number (SSN) for each covered dependent. The SSN is not required for a dependent child until age two. However, failure to provide the SSN when the child reaches age two will result in termination of coverage for the dependent child. Provide the SSN for a dependent child as soon as it is available.

***Note:** When you add a dependent, the Plan will request dependent verification documentation. You must submit the documentation requested by the Plan before coverage will be granted and claims paid. Send documentation to SHBP, P.O. Box 1990, Atlanta, GA 30301-1990. Do not hold the request waiting for documentation. If documentation is received after 31 days (except for newborn), the plan will cover the dependent retroactively to the beginning of the current plan year or date of qualifying event, whichever is later, as long as premiums are paid.

The following chart shows qualifying events and the corresponding changes that active members can make. If you are new enrolling the health plan because of a qualifying event your plan options are restricted to the standard Consumer Driven Plans (the Standard Health Reimbursement Arrangement (HRA) and the Standard High Deductible Health Plan (HDHP), for the first plan year. Once enrolled you may select any available heath plan option during the following Open Enrollment.

A general note regarding documentation sent to the Plan: SHBP requires that coverage requests are made within a specific time period and requires documentation to support the request. When SHBP requests documentation, if the documentation is not received within 31 days of the SHBP request, the effective date of the coverage change will be the later of the qualifying event date or first day of the plan year.

Add/Required Documentation	Within 90 days you may/must	Coverage Takes Effect
Birth Copy of certified birth certificate or birth card from hospital showing parents names. Copy of Social Security Number not required until age two. Failure to provide the Social Security Number at age two will result in termination of coverage for the dependent child.	• Enroll in coverage; • Change your coverage tier to include child(ren); • Enroll your eligible dependents; or • Change coverage option to elect new coverage for you + child(ren), or you + family.	On the first day of the month following the request; or On the day your child was born, if the proper premiums are paid, starting with premiums for the birth month.

Add/Required Documentation	Within 31 days of qualifying event you may/must	Coverage Takes Effect
Adoption or legal guardianship 1) Adoption: Certified copy of court order documents establishing adoption and stating the date of adoption, or if adoption is not finalized certified or notarized legal documents establishing the date of placement for adoption. If certified copy of the birth certificate is not available, other proof of the child's date of birth is required. Copy of Social Security Number not required until age two. Failure to provide the Social Security Number when the child reaches age two will result in termination of coverage for the dependent child. 2) 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. Copy of Social Security Number not required until age two. Failure to provide the Social Security Number when the child reaches age two will result in termination of coverage for the dependent child.	• Enroll in coverage; • Change your coverage tier to include child(ren); • Enroll your eligible dependents; or • Change coverage option to elect new coverage for you + child(ren), or you + family. Note: For adoption and legal guardianship for a newborn – you have 90 days to add	On the first day of the month following the request; or **Adoption:** ***If you already have coverage that includes children:*** On the date of legal placement and physical custody. ***If you do not have a tier that covers dependent children:*** On the date of legal placement and physical custody, if the proper premiums are paid, starting with the month of placement and physical custody.
Disabled child • Proof of the child's disability and dependency requirements furnished to DCH, SHBP Division within 31 days of: enrollment in the Plan; or date coverage would otherwise have ended because the disabled dependent child reached age 26. Social Security Number not required until age two. Failure to provide the Social Security Number when the child reaches age two will result in termination of coverage for the dependent child. DCH, SHBP Division may periodically ask you for proof that the Member's child continues to meet these conditions of disability and dependency.	• Enroll in coverage; • Change your coverage tier to include child(ren); • Enroll your eligible dependents; or • Change coverage option to elect new coverage for you + child(ren), or you + family.	• On the first of the month following approval of the medical documentation submitted to DCH, SHBP Division When you have changed tiers to cover the disabled dependent child

Add/Required Documentation	Within 31 days of qualifying event you may/must	Coverage Takes Effect
Marriage Certified copy of marriage certificate required and Social Security Number.	• Enroll for coverage; • Change your coverage tier to include spouse; • Change coverage option to elect new coverage for you + spouse or you + family; or • Discontinue coverage. You must submit a letter from the other plan documenting that you and your covered dependents are enrolled in your spouse's plan. The letter should include the names of all covered dependents.	On the first day of the month following the request or date of marriage, if proper premium is paid for the marriage month and request is made the month prior to marriage.
Stepchild(ren) Copy of certified birth certificate showing your spouse is the natural parent; copy of certified marriage license showing the natural parent is your spouse 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 and Social Security Number.	• Enroll in coverage; • Change your coverage tier; • Enroll your eligible dependents; or • Change coverage option to elect new coverage for you + child(ren), or you + family. Note: (90 days to add a newborn)	On the first day of the month following your change to the appropriate coverage tier if proper premium is paid for
Divorce Copy of divorce decree and loss-of-coverage documentation required and you must furnish the Social Security Number for each dependent you wish to cover.	• Enroll in coverage, if losing coverage through your spouse's plan; • You must remove your spouse from coverage; • You must remove your stepchildren from coverage; • Change your coverage tier; • Enroll your eligible dependent(s); or • Change coverage option to elect new coverage for you or you + child(ren).	On the first day of the month following your change to the appropriate coverage tier

Add/Required Documentation	Within 31 days of qualifying event you may/must	Coverage Takes Effect
You or your spouse loses coverage through other employment Letter from other employer documenting loss of coverage and reason for loss. You must furnish the Social Security Number and dependent verification for each dependent you wish to cover.	• Enroll your eligible dependent(s); • Enroll in coverage; • Change your coverage tier; or • Change coverage option to elect new coverage for you, you + spouse or you + child(ren) or you + family.	On the first day of the month following your change to the appropriate coverage tier
You, your spouse, or enrolled dependent are covered under a qualified health plan and you lose eligibility, such as through other employment, Medicaid, SCHIP or Medicare Letter from other employer, Medicaid, or Medicare documenting date and reason for loss or discontinuation. You must furnish the Social Security Number and dependent verification for each dependent you wish to cover.	• Enroll in coverage; • Enroll your eligible dependent(s); • Change your coverage tier; or • Change coverage option to elect new coverage for you, you + spouse or you + child(ren) or you + family. *Note: For loss of Medicaid or SCHIP coverage, you have 60 days for actions above.*	On the first day of the month following your change to the appropriate coverage tier
Loss of dependent(s) that impacts your Tier (i.e., loss of all eligible dependents – you may change tiers to your coverage). i.e., Child reaches age 26. Provide documentation stating the reason and date eligibility was lost unless loss of coverage is due to dependent reaching age 26	• Change your coverage tier; or • Change coverage option to elect new coverage for you or you + spouse.	On the first day of the month following your change to the appropriate coverage tier
Your former spouse loses other qualified coverage resulting in loss of your dependent child(ren)'s coverage under former spouse's plan Furnish Social Security Number and dependent verification for each dependent you wish to cover Letter from other plan documenting name(s) of everyone who lost coverage, date, reason, and when coverage was lost.	• Enroll in coverage; • Enroll eligible dependents(s); • Change coverage option to elect new coverage for you + child(ren) or you + family; or • Increase coverage tier	On the first day of the month following your change to the appropriate coverage tier

Add/Required Documentation	Within 31 days of qualifying event you may/must	Coverage Takes Effect
Covered Dependent loses Eligibility. Provide documentation stating the reason and date eligibility was lost, unless reason for loss of coverage is because of reaching age 26	• Change coverage tier to remove ineligible spouse and/or dependent(s); or • Change coverage option to elect new coverage for you, you + spouse or you + child(ren) or you + family.	On the first day of the month following your change to the appropriate coverage tier
Gain of coverage due to other employer's open enrollment Furnish Social Security Number for each dependent you wish to cover. Letter from other employer documenting name(s) of everyone who gained coverage, date, reason, and when coverage was gained. **Note: Plan year can be the same but OE dates must be different.**	• Change coverage tier to remove spouse and/or dependent(s); or • Discontinue coverage.	On the first day of the month following your change to the appropriate coverage tier
Loss of coverage due to other employer's open enrollment Furnish Social Security Number for each dependent you wish to cover. Letter from other employer documenting name(s) of everyone who lost coverage, date, reason is due to open enrollment, and when coverage was lost. Note: Plan year can be the same but OE dates must be different.	• Enroll eligible dependent(s); • Enroll In Coverage; or • Change coverage option to elect new coverage for you or you + spouse or you + child(ren) or you + family.	On the first day of the month following your change to the appropriate coverage tier
Your spouse or your only enrolled dependent's employment status changes, resulting in a gain of coverage under a qualified plan other than SHBP Letter from other employer documenting name(s) of everyone who gained coverage, date, reason, and when coverage was gained.	• Change coverage tier to remove spouse and/or dependent(s); • Change coverage option; or • Discontinue coverage.	On the first day of the month following your change to the appropriate coverage tier

Add/Required Documentation	Within 31 days of qualifying event you may/must	Coverage Takes Effect
You or spouse acquire new coverage under spouse's employer's plan Letter from other plan documenting the effective date of coverage, names of everyone who gained coverage, date, and reason coverage was gained.	• Change tier to you only coverage; • Discontinue coverage. You must document that all members removed from SHBP coverage are covered under the other employer's plan; or • Change coverage option to elect new coverage for you or you + child(ren).	On the first day of the month following your change to the appropriate coverage tier
You or your spouse is activated into military services Copy of orders required and you must furnish the Social Security Number and dependent verification for each dependent you wish to cover.	• Enroll in coverage; • Change your coverage tier; • Discontinue coverage; or • Change coverage option to elect new coverage for you or you + spouse or you + child(ren) or you + family	On the first day of the month following your change to the appropriate coverage tier
You retire and immediately qualify for a retirement annuity with a State Retirement System other than ERS, TRS or PSERS, you must complete and submit the Retiree/Surviving Spouse Form no later than 60 days after leaving active employment. It is your responsibility to verify that the health insurance deduction was taken from your initial retirement check.	• Change coverage tier to you only; • Change Option; or • Discontinue Coverage.	On the first day of the month following your change to the appropriate coverage tier
You return to work as an active employee with an employing entity under the Plan, either immediately after you retire or at a later date, your retirement annuity may be suspended or continued but your health insurance must be through your active employment. You must complete the New Enrollment/Transfer Form.	• Select coverage as active employee; • Change Option; or • Change coverage tier	On the first day of the month following your change to the appropriate coverage tier

You stop work as an active employee You must complete the Retiree/Surviving Spouse Form to set up your deductions through the retirement system again. Annuitants coverage may be reinstated if you notify DCH, SHBP Division within 60 days. You must have continuous coverage, based on the conditions that first made you eligible as a retiree.	• Change Option; or • Decrease tier	On the first day of the month following your change to the appropriate coverage tier
• **You retire and immediately qualify for a retirement annuity under the Georgia ERS, TRS or PSERS retirement system**, Coverage will automatically roll to the same option and tier you had as an active employee unless you have Medicare Part B coverage. Employees or covered dependents with Medicare Part B coverage will roll to the Medicare Advantage standard option. Automatic deductions for health coverage only start when the Retiree receives his/her initial retirement check from ERS, TRS or PSERS. It is your responsibility to verify that the health insurance deduction was taken from your initial retirement check.	• Lower coverage tier; • Change Option; or • Discontinue Coverage.	On the first day of the month following your change to the appropriate coverage tier
If you are working in a benefits eligible position and are continuing to receive your retirement annuity, you must advise SHBP when you terminate your benefits, eligible position or you will not have health coverage as a retiree.	• Change coverage; • Change Option; or • Discontinue Coverage.	On the first day of the month following your change to the appropriate coverage tier
Spouse's Loss of Eligibility for Health Insurance due to Retirement Loss of eligibility for health insurance at retirement is a qualifying event. Retirement without loss of eligibility for health coverage; discontinuation of coverage, reduction of benefits or change in premiums ARE NOT qualifying events.	• Change option tier to add spouse; • Change coverage option to elect new coverage for you, you + spouse, you + child(ren) or you + family; • Lower coverage tier; or • Discontinue coverage	On the first day of the month following your change to the appropriate coverage tier

Add/Required Documentation	Within 31 days of qualifying event you may/must	Coverage Takes Effect
You, your spouse, or enrolled dependents turn 65 Required to submit proof of enrollment in Part B. If you are actively working, enrollment in Medicare will not reduce your premiums. SHBP will remain primary as long as you are actively working unless you drop your SHBP coverage. However, once you stop working, premiums and options are based on enrollment in Medicare Part B. You will have 2 additional MA options. To receive the state subsidy, you will need to enroll in one of the MA options. You must enroll in Medicare Part B and continue to pay Part B premiums to enroll in a SHBP MA Option. A copy of your Medicare card should be submitted 30 days prior to the retirement or the month you or your covered spouse turns 65. **Note:** The HDHP is not a creditable plan for your Medicare prescription drug coverage. If you are enrolled in a HDHP option, you must enroll in a Medicare Part D Plan, even if actively working or a Medicare Advantage Plan when you first become eligible, or you will pay a late enrollment penalty of at least 1 percent (up to a maximum of 19 percent) for the period you did not have creditable coverage. This penalty will apply each month whether you are in the Medicare Advantage Plan or an individual Part D Plan. SHBP Medicare Advantage Plans include Part D prescription drug coverage.	As an Active Employee: • Change coverage tiers; • If no eligible dependent(s), discontinue coverage As a Retiree: • Discontinue your dependent(s) coverage or drop SHBP coverage. If you discontinue your SHBP coverage when you enroll for Medicare, you won't be able to enroll again for SHBP coverage unless you return to work in a position that offers SHBP coverage • Retirees may change to any available option upon becoming eligible for Medicare coverage but you will lose the state's contribution toward your health coverage if you do not enroll in a Medicare Advantage option at age 65 • See the Retiree Section for more information	On the first day of the month following your change to the appropriate coverage tier

Loss of all covered dependents may be through divorce, death, an only covered dependent exceeding the maximum age of eligibility, or a Qualified Medical Child Support Order (QMCSO) requiring a former spouse to provide health coverage for all covered natural children. You must notify SHBP within 31 days of qualifying event (90 days for a newborn) to change your coverage tier.

Identification Cards

After you enroll, you will receive a separate identification (ID) card for yourself and each covered dependent. The ID card must be presented when care is received.

If you do not receive your ID card within two weeks of enrollment, please contact CIGNA Customer Service at

800-633-8519 (Active) or 800-942-6724 (Retiree).

Open Access Plus Medical Benefits

Inpatient Certification Requirements - Out-of-Network

For You and Your Dependents

Pre-Admission Certification/Continued Stay Review for Hospital Confinement

Pre-Admission Certification (PAC) and Continued Stay Review (CSR) refer to the process used to certify the Medical Necessity and length of a Hospital Confinement when you or your Dependent require treatment in a Hospital:

- as a registered bed patient;
- for a Partial Hospitalization for the treatment of Mental Health or Substance Abuse.

You or your Dependent should request PAC prior to any non-emergency treatment in a Hospital described above. In the case of an emergency admission, you should contact the Review Organization within 24 hours after the admission. For an admission due to pregnancy, you should call the Review Organization by the end of the third month of pregnancy. CSR should be requested, prior to the end of the certified length of stay, for continued Hospital Confinement.

Covered Expenses incurred will be reduced by 50% for Hospital charges made for each separate admission to the Hospital:

- **unless PAC is received: (a) prior to the date of admission; or (b) in the case of an emergency admission, within 24 hours after the date of admission.**

Covered Expenses incurred for which benefits would otherwise be payable under this plan for the charges listed below will not include:

- **Hospital charges for Bed and Board, for treatment listed above for which PAC was performed, which are made for any day in excess of the number of days certified through PAC or CSR; and**
- **any Hospital charges for treatment listed above for which PAC was requested, but which was not certified as Medically Necessary.**

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PAC and CSR are performed through a utilization review program by a Review Organization with which CIGNA has contracted.

In any case, those expenses incurred for which payment is excluded by the terms set forth above will not be considered as expenses incurred for the purpose of any other part of this plan, except for the "Coordination of Benefits" section.

Note: Obtaining pre-certification for an inpatient admission does not guarantee coverage. Be sure to review your plan guidelines carefully.

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Outpatient Certification Requirements Out-of-Network

Outpatient Certification refers to the process used to certify the Medical Necessity of outpatient diagnostic testing and outpatient procedures, including, but not limited to, those listed in this section when performed as an outpatient in a Free-standing Surgical Facility, Other Health Care Facility or a Physician's office. You or your Dependent should call the toll-free number on the back of your I.D. card to determine if Outpatient Certification is required prior to any outpatient diagnostic testing or procedures. Outpatient Certification is performed through a utilization review program by a Review Organization with which CIGNA has contracted. Outpatient Certification should only be requested for nonemergency procedures or services, and should be requested by you or your Dependent at least four working days (Monday through Friday) prior to having the procedure performed or the service rendered.

Covered Expenses incurred will be reduced by 50% for charges made for any outpatient diagnostic testing or procedure performed unless Outpatient Certification is received prior to the date the testing or procedure is performed.

Covered Expenses incurred will not include expenses incurred for charges made for outpatient diagnostic testing or procedures for which Outpatient Certification was performed, but, which was not certified as Medically Necessary.

In any case, those expenses incurred for which payment is excluded by the terms set forth above will not be considered as expenses incurred for the purpose of any other part of this plan, except for the "Coordination of Benefits" section.

Diagnostic Testing and Outpatient Procedures

Including, but not limited to:

- Advanced radiological imaging – CT Scans, MRI, MRA or PET scans.
- Hysterectomy.

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Prior Authorization/Pre-Authorized

The term Prior Authorization means the approval that a Provider must receive from the Review Organization, prior to services being rendered, in order for certain services and benefits to be covered under this policy. Penalties will apply when items are not pre-authorized. Please see penalties outlined on the previous page.

Services that require Prior Authorization include, but are not limited to:

- inpatient Hospital services;
- inpatient services at any participating Other Health Care Facility;
- outpatient facility services;
- intensive outpatient programs;
- advanced radiological imaging;
- nonemergency ambulance;
- transplant services; or
- durable medical equipment in excess of $250.

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OPEN ACCESS PLUS MEDICAL BENEFITS
The Schedule

For You and Your Dependents

Open Access Plus Medical Benefits provide coverage for care In-Network and Out-of-Network. To receive Open Access Plus Medical Benefits, you and your Dependents may be required to pay a portion of the Covered Expenses for services and supplies. That portion is the Deductible or Coinsurance.

Coinsurance

The term Coinsurance means the percentage of charges for Covered Expenses that an insured person is required to pay under the plan. If the Eligible Expenses are less than the billed charges for a Network Provider, you will not be responsible for paying the difference to the provider. If the Eligible Expenses are less than the billed charges for an Out-of-Network Provider, you will be responsible for paying the difference to the provider.

Deductibles

Deductibles are in addition to any Coinsurance. Once the Deductible maximum in The Schedule has been reached during the calendar year, you and your family need not satisfy any further medical deductible for the remainder of that calendar year.

Out-of-Pocket Expenses

Out-of-Pocket Expenses are Covered Expenses incurred for In-Network and Out-of-Network charges that are not paid by the benefit plan because of any:

- Coinsurance.
- Plan Deductibles.

Charges will not accumulate toward the Out-of-Pocket Maximum for Covered Expenses incurred for:

- non-compliance penalties.
- provider charges in excess of the Maximum Reimbursable Charge.

When the Out-of-Pocket Maximum shown in The Schedule is reached, Injury and Sickness benefits are payable at 100% except for:

- non-compliance penalties.
- provider charges in excess of the Maximum Reimbursable Charge.

Accumulation of Plan Deductibles and Out-of-Pocket Maximums

Deductibles and Out-of-Pocket Maximums will accumulate in one direction (e.g. Out-of-Network will accumulate to In-Network). All other plan maximums and service-specific maximums (dollar and occurrence) cross-accumulate between In- and Out-of-Network unless otherwise noted.

Multiple Surgical Reduction

Multiple surgeries performed during one operating session result in payment reduction of 50% to the surgery of lesser charge. The most expensive procedure is paid as any other surgery.

OPEN ACCESS PLUS MEDICAL BENEFITS

The Schedule

Assistant Surgeon and Co-Surgeon Charges

Assistant Surgeon

The maximum amount payable will be limited to charges made by an assistant surgeon that do not exceed 20 percent of the surgeon's allowable charge. (For purposes of this limitation, allowable charge means the amount payable to the surgeon prior to any reductions due to coinsurance or deductible amounts.)

Co-Surgeon

The maximum amount payable will be limited to 62.5 percent of the surgeon's allowable charge. (For purposes of this limitation, allowable charge means the amount payable to the surgeons prior to any reductions due to deductible amounts.)

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Lifetime Maximum	Unlimited	
Coinsurance Levels	80% of Covered Expenses	60% of Maximum Reimbursable Eligible Expenses
Collective Deductible: All family members contribute towards the family deductible. An individual cannot have claims covered under the plan coinsurance until the total family deductible has been satisfied.		
Calendar Year Deductible for Active Employees and Retirees		
You	$1,750	$3,500
You + Spouse	$3,500	$7,000
You + Child(ren)	$3,500	$7,000
You + Family	$3,500	$7,000
Combined Medical/Pharmacy Calendar Year Deductible		
Combined Medical/Pharmacy Deductible: includes retail drugs	Yes	Not Applicable

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Collective Out-of-Pocket Maximum: All family members contribute towards the family Out-of-Pocket. An individual cannot have claims covered at 100% of eligible expenses until the total family Out-of-Pocket has been satisfied.		
Out-of-Pocket Maximum for Active Employees and Retirees		
You	$2,650	$5,800
You + Spouse	$4,600	$10,800
You + Child(ren)	$4,600	$10,800
You + Family	$4,600	$10,800
Combined Medical/Pharmacy Out-of-Pocket Maximum		
Combined Medical/Pharmacy Out-of-Pocket: Includes retail drugs	Yes	Not Applicable

Out-of-Pocket Expenses

Out-of-Pocket Expenses are Covered Expenses incurred for In-Network and Out-of-Network charges that are not paid by the benefit plan because of any:

- Coinsurance.
- Plan Deductibles.

Charges will not accumulate toward the Out-of-Pocket Maximum for Covered Expenses incurred for:

- non-compliance penalties.
- provider charges in excess of the Maximum Reimbursable Charge.

When the Out-of-Pocket Maximum shown in The Schedule is reached, Injury and Sickness benefits are payable at 100% of eligible charges except for:

- non-compliance penalties.
- provider charges in excess of the Maximum Reimbursable Charge.

Note: Charges from nonparticipating providers are subject to balance billing. In these situations, you may be billed for the amount that exceeds the maximum reimbursable eligible charge. These charges are the member's responsibility and do not count toward deductibles or out-of-pocket spending limits.

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

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Physician's Services		
Primary Care Physician's Office visit	80% of Covered Expenses after plan deductible	60% of Maximum Reimbursable Eligible Expenses after plan deductible
Specialty Care Physician's Office Visits, Consultant and Referral Physician's Services	80% of Covered Expenses after plan deductible	60% of Maximum Reimbursable Eligible Expenses after plan deductible
Surgery Performed In the Physician's Office	80% of Covered Expenses after plan deductible	60% of Maximum Reimbursable Eligible Expenses after plan deductible
Second Opinion Consultations (provided on a voluntary basis)	80% of Covered Expenses after plan deductible	60% of Maximum Reimbursable Eligible Expenses after plan deductible
Allergy Treatment/Injections	80% of Covered Expenses after plan deductible	60% of Maximum Reimbursable Eligible Expenses after plan deductible
Allergy Serum (dispensed by the Physician in the office)	80% of Covered Expenses after plan deductible	60% of Maximum Reimbursable Eligible Expenses after plan deductible
Preventive Care		
Physician's Office Visit	100% coverage	In-Network coverage only
Immunizations	100% coverage	In-Network coverage only
Routine Mammograms, PSA, Pap Smear One exam per calendar year	100% coverage	In-Network coverage only
Routine Colonoscopy Screenings One exam per calendar year	100% coverage	In-Network coverage only

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Inpatient Hospital - Facility Services	80% of Covered Expenses after plan deductible	60% of Maximum Reimbursable Eligible Expenses after plan deductible **** Pre-authorization required***
Semi-Private Room and Board	Limited to the semi-private room negotiated rate	Limited to the semi-private room rate
Private Room	Limited to the semi-private room negotiated rate	Limited to the semi-private room rate
Special Care Units (ICU/CCU)	Limited to the negotiated rate	Limited to the ICU/CCU daily room rate
Outpatient Facility Services Operating Room, Recovery Room, Procedures Room, Treatment Room and Observation Room	80% of Covered Expenses after plan deductible	60% of Maximum Reimbursable Eligible Expenses after plan deductible **** Pre-authorization may be required***
Inpatient Hospital Physician's Visits/Consultations	80% of Covered Expenses after plan deductible	60% of Maximum Reimbursable Eligible Expenses after plan deductible
Inpatient Hospital Professional Services Surgeon Radiologist Pathologist Anesthesiologist	80% of Covered Expenses after plan deductible	60% of Maximum Reimbursable Eligible Expenses after plan deductible
Outpatient Professional Services Surgeon Radiologist Pathologist Anesthesiologist	80% of Covered Expenses after plan deductible	60% of Maximum Reimbursable Eligible Expenses after plan deductible

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Emergency and Urgent Care Services		
Physician's Office Visit	80% of Covered Expenses after plan deductible	
Hospital Emergency Room	80% of Covered Expenses after plan deductible	
Outpatient Professional services (radiology, pathology and ER Physician)	80% of Covered Expenses after plan deductible	
Urgent Care Facility or Outpatient Facility	80% of Covered Expenses after plan deductible	
X-ray and/or Lab performed at the Emergency Room/Urgent Care Facility (billed by the facility as part of the ER/UC visit)	80% of Covered Expenses after plan deductible	
Independent x-ray and/or Lab Facility in conjunction with an ER visit	80% of Covered Expenses after plan deductible	
Advanced Radiological Imaging (i.e. MRIs, MRAs, CAT Scans, PET Scans etc.)	80% of Covered Expenses after plan deductible	
Ambulance (non-emergency transportation, ground or air, is excluded, unless approved by CIGNA)	80% of Covered Expenses after plan deductible	
Skilled Nursing Facilities (including Sub-Acute Facilities) Calendar Year Maximum: 120 days	80% of Covered Expenses after plan deductible.	Covered In-network Only
Rehabilitation Hospitals (including Inpatient Long Term Acute Care) Calendar Year Maximum: Unlimited days	80% of Covered Expenses after plan deductible	60% of Maximum Reimbursable Eligible Expenses after plan deductible **** Pre-authorization required***

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Laboratory and Radiology Services (including pre-admission testing)		
Physician's Office Visit	80% of Covered Expenses after plan deductible	60% of Maximum Reimbursable Eligible Expenses after plan deductible
Outpatient Hospital Facility	80% of Covered Expenses after plan deductible	60% of Maximum Reimbursable Eligible Expenses after plan deductible
Independent X-ray and/or Lab Facility	80% of Covered Expenses after plan deductible	60% of Maximum Reimbursable Eligible Expenses after plan deductible
Advanced Radiological Imaging (i.e. MRIs, MRAs, CAT Scans and PET Scans)		**** Pre-authorization required***
Inpatient Facility	80% of Covered Expenses after plan deductible	60% of Maximum Reimbursable Eligible Expenses after plan deductible
Outpatient Facility	80% of Covered Expenses after plan deductible	60% of Maximum Reimbursable Eligible Expenses after plan deductible
Physician's Office Visit	80% of Covered Expenses after plan deductible	60% of Maximum Reimbursable Eligible Expenses after plan deductible

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Outpatient Short-Term Rehabilitative Therapy Calendar Year Maximum: 40 days per therapy Includes: Cardiac Rehab Physical Therapy Speech Therapy Occupational Therapy Pulmonary Rehab Cognitive Therapy *Note: 40 days equals 40 visits per therapy. Treatment is limited to one visit per day.* *Physical Therapy may be extended for children with congenital anomalies that required surgical correction. See page 64.*	80% of Covered Expenses after plan deductible	60% of Maximum Reimbursable Eligible Expenses after plan deductible **** Pre-authorization required***
Chiropractic Care Calendar Year Maximum: 20 days	80% of Covered Expenses after plan deductible	60% of Maximum Reimbursable Eligible Expenses after plan deductible
Home Health Care Calendar Year Maximum: Unlimited when prior approved by CIGNA (includes outpatient private nursing when approved as medically necessary)	80% of Covered Expenses after plan deductible	60% of Maximum Reimbursable Eligible Expenses after plan deductible **** Pre-authorization required***
Hospice/Bereavement Counseling		**** Pre-authorization required***
Inpatient Services	80% of Covered Expenses after plan deductible	60% of Maximum Reimbursable Eligible Expenses after plan deductible
Outpatient Services	80% of Covered Expenses after plan deductible	60% of Maximum Reimbursable Eligible Expenses after plan deductible

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Maternity Care Services		
Initial Visit to Confirm Pregnancy	80% of Covered Expenses after plan deductible	60% of Maximum Reimbursable Eligible Expenses after plan deductible
All subsequent Prenatal Visits, Postnatal Visits and Physician's Delivery Charges (i.e. global maternity fee)	80% of Covered Expenses after plan deductible	60% of Maximum Reimbursable Eligible Expenses after plan deductible
Physician's Office Visits in addition to the global maternity fee when performed by an OB/GYN or Specialist	80% of Covered Expenses after plan deductible	60% of Maximum Reimbursable Eligible Expenses after plan deductible
Delivery - Facility (Inpatient Hospital, Birthing Center)	80% of Covered Expenses after plan deductible	60% of Maximum Reimbursable Eligible Expenses after plan deductible
Abortion Includes elective and non-elective procedures		
Physician's Office Visit	80% of Covered Expenses after plan deductible	60% of Maximum Reimbursable Eligible Expenses after plan deductible
Inpatient Facility	80% of Covered Expenses after plan deductible	60% of Maximum Reimbursable Eligible Expenses after plan deductible **** Pre-authorization required***
Outpatient Facility	80% of Covered Expenses after plan deductible	60% of Maximum Reimbursable Eligible Expenses after plan deductible **** Pre-authorization required***
Physician's Services	80% of Covered Expenses after plan deductible	60% of Maximum Reimbursable Eligible Expenses after plan deductible

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Family Planning Services		
Office Visits, Lab and Radiology Tests and Counseling **Note:** Includes coverage for contraceptive devices (e.g. Depo-Provera and Intrauterine Devices (IUDs). Diaphragms will also be covered when services are provided in the physician's office. Surgical Sterilization Procedures for Vasectomy/Tubal Ligation (excludes reversals)	80% of Covered Expenses after plan deductible	60% of Maximum Reimbursable Eligible Expenses after plan deductible
Physician's Office Visit	80% of Covered Expenses after plan deductible	60% of Maximum Reimbursable Eligible Expenses after plan deductible
Inpatient Facility	80% of Covered Expenses after plan deductible	60% of Maximum Reimbursable Eligible Expenses after plan deductible **** Pre-authorization required***
Outpatient Facility	80% of Covered Expenses after plan deductible	60% of Maximum Reimbursable Eligible Expenses after plan deductible **** Pre-authorization required***
Physician's Services	80% of Covered Expenses after plan deductible	60% of Maximum Reimbursable Eligible Expenses after plan deductible

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Infertility Treatment Services Not Covered include: • Testing performed specifically to determine the cause of infertility. • Treatment and/or procedures performed specifically to restore fertility (e.g. procedures to correct an infertility condition). • Artificial means of becoming pregnant (e.g. Artificial Insemination, In-vitro, GIFT, ZIFT, etc).	Note: Coverage will be provided for the treatment of an underlying medical condition up to the point an infertility condition is diagnosed. Services will be covered as any other illness.	Note: Coverage will be provided for the treatment of an underlying medical condition up to the point an infertility condition is diagnosed. Services will be covered as any other illness.
Organ Transplants Includes all medically appropriate, non-experimental transplants	*Note: Cornea transplants are not covered at CIGNA Lifesource Facilities. These services will be covered at the CIGNA Participating Provider benefit level.*	
Physician's Office Visit	80% of Covered Expenses after plan deductible	In-Network coverage only
Inpatient Facility		
CIGNA Lifesource Transplant Network Facility	100% of Covered Expenses after plan deductible	In-Network coverage only
Non-Lifesource, CIGNA Contracted Facility	80% of Covered Expenses after plan deductible	In-Network coverage only
Physician's Services		
CIGNA Lifesource Transplant Network Provider	100% of Covered Expenses after plan deductible	In-Network coverage only
Non-Lifesource, CIGNA Contracted Provider	80% of Covered Expenses after plan deductible	In-Network coverage only
Lifetime Travel Maximum: $10,000 per transplant	100% coverage (only available when using Lifesource facility)	In-Network coverage only

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Durable Medical Equipment Calendar Year Maximum: Unlimited	80% of Covered Expenses after plan deductible ***Note: Items over $250 may require pre-authorization.***	60% of Maximum Reimbursable Eligible Expenses after plan deductible ***Note: Items over $250 may require pre-authorization.***
External Prosthetic Appliances Essential: Calendar Year Maximum: Unlimited Non-Essential: Calendar Year Maximum: $50,000 *See definitions of essential and non-essential prosthetic appliances on page 63	80% of Covered Expenses after plan deductible	60% of Maximum Reimbursable Eligible Expenses after plan deductible **** Pre-authorization required***
Hearing Services **Note:** Includes exam and fitting of hearing aids.	80% of Covered Expenses after plan deductible	80% of Covered Expenses after in-network plan deductible
Hearing Aids Maximum: $1,500 every five (5) calendar years	100% of Covered Expenses after plan deductible	100% of Covered Expenses after plan deductible
Wigs Limited to charges for hair loss related to cancer/chemotherapy treatment Maximum: $750 per lifetime	100% of Covered Expenses after plan deductible	100% of Covered Expenses after plan deductible
Nutritional Evaluation and Counseling		
Physician's Office Visit	80% of Covered Expenses after plan deductible	80% of Covered Expenses after plan deductible
Inpatient Facility	80% of Covered Expenses after plan deductible	80% of Covered Expenses after plan deductible
Outpatient Facility	80% of Covered Expenses after plan deductible	80% of Covered Expenses after plan deductible
Physician's Services	80% of Covered Expenses after plan deductible	80% of Covered Expenses after plan deductible

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Accidental Dental Limited to charges made for a continuous course of dental treatment started within six months of an injury to sound, natural teeth.		
Physician's Office Visit	80% of Covered Expenses after plan deductible	60% of Maximum Reimbursable Eligible Expenses after plan deductible
Inpatient Facility	80% of Covered Expenses after plan deductible	60% of Maximum Reimbursable Eligible Expenses after plan deductible **** Pre-authorization required***
Outpatient Facility	80% of Covered Expenses after plan deductible	60% of Maximum Reimbursable Eligible Expenses after plan deductible **** Pre-authorization required***
Physician's Services	80% of Covered Expenses after plan deductible	60% of Maximum Reimbursable Eligible Expenses after plan deductible

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
TMJ Surgical and Non-Surgical Always excludes appliances and orthodontic treatment. Subject to medical necessity.		
Physician's Office Visit	80% of Covered Expenses after plan deductible	60% of Maximum Reimbursable Eligible Expenses after plan deductible
Inpatient Facility	80% of Covered Expenses after plan deductible	60% of Maximum Reimbursable Eligible Expenses after plan deductible **** Pre-authorization required***
Outpatient Facility	80% of Covered Expenses after plan deductible	60% of Maximum Reimbursable Eligible Expenses after plan deductible **** Pre-authorization required***
Physician's Services *Note: Coverage for diagnostic testing and non-surgical treatment up to $1,100 per person per lifetime maximum benefit. Coverage for Occlusal Orthotic (splints) appliances: $500 per person per lifetime maximum benefit.*	80% of Covered Expenses after plan deductible	60% of Maximum Reimbursable Eligible Expenses after plan deductible

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Bariatric Surgery The following are excluded : • Coverage of Bariatric Surgery to treat clinically severe obesity. • Medical and surgical services to alter appearances or physical changes that are the result of any surgery performed for the management of obesity or clinically severe (morbid) obesity. • Weight loss programs or treatments, whether prescribed or recommended by a physician or under medical supervision.	Not covered	Not covered
Routine Foot Disorders	Not covered except for services associated with foot care for diabetes and peripheral vascular disease.	Not covered except for services associated with foot care for diabetes and peripheral vascular disease.

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Treatment Resulting From Life Threatening Emergencies Related to Mental Health or Substance Abuse Conditions Medical treatment required as a result of an emergency, such as a suicide attempt, will be considered a medical expense until the medical condition is stabilized. Once the medical condition is stabilized, whether the treatment will be characterized as either a medical expense or a mental health/substance abuse expense will be determined by the utilization review Physician in accordance with the applicable mixed services claim guidelines.		
Mental Health **(All Services require pre-authorization)**		
Inpatient	80% of Covered Expenses after plan deductible	60% of Maximum Reimbursable Eligible Expenses after plan deductible
Outpatient Physician's Office	80% of Covered Expenses after plan deductible	60% of Maximum Reimbursable Eligible Expenses after plan deductible
Outpatient Facility	80% of Covered Expenses after plan deductible	60% of Maximum Reimbursable Eligible Expenses after plan deductible
Substance Abuse **(All Services require pre-authorization)**		
Inpatient	80% of Covered Expenses after plan deductible	60% of Maximum Reimbursable Eligible Expenses after plan deductible
Outpatient Physician's Office	80% of Covered Expenses after plan deductible	60% of Maximum Reimbursable Eligible Expenses after plan deductible
Outpatient Facility	80% of Covered Expenses after plan deductible	60% of Maximum Reimbursable Eligible Expenses after plan deductible

Covered Expenses

The term Covered Expenses means the expenses incurred by or on behalf of a person for the charges listed below if they are incurred after becoming insured for these benefits. Expenses incurred for such charges are considered Covered Expenses to the extent that the services or supplies provided are recommended by a Physician, and are Medically Necessary for the care and treatment of an Injury or a Sickness, as determined by CIGNA.

Covered Expenses

- Charges made by a Hospital, on its own behalf, for Bed and Board and other Necessary Services and Supplies; except that for any day of Hospital Confinement, Covered Expenses will not include that portion of charges for Bed and Board which is more than the Bed and Board Limit shown in The Schedule.
- Charges for licensed ambulance service to or from the nearest Hospital where the needed medical care and treatment can be provided.
- Charges made by a Hospital, on its own behalf, for medical care and treatment received as an outpatient.
- Charges made by a Free-Standing Surgical Facility, on its own behalf for medical care and treatment.
- Charges made on its own behalf, by an Other Health Care Facility, including a Skilled Nursing Facility, a Rehabilitation Hospital or a subacute facility for medical care and treatment; except that for any day of Other Health Care Facility confinement, Covered Expenses will not include that portion of charges which are in excess of the Other Health Care Facility Daily Limit shown in The Schedule.
- Charges made for Emergency Services and Urgent Care.
- Charges made by a Physician or a Psychologist for professional services.
- Charges made by a Nurse, other than a member of your family or your Dependent's family, for professional nursing service.

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- Charges made for anesthetics and their administration; diagnostic x-ray and laboratory examinations; x-ray, radium, and radioactive isotope treatment; chemotherapy; blood transfusions; oxygen and other gases and their administration.

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- Charges made for a mammogram for women ages 35 to 69, every one to two years, or at any age for women at risk, when recommended by a Physician.
- Charges made for an annual Papanicolaou laboratory screening test.
- Charges for annual ovarian cancer surveillance tests for women age 35 and over at risk for ovarian cancer. Annual ovarian cancer surveillance tests are annual screenings using CA-125 serum tumor marker testing, transvaginal ultrasound, and pelvic examination. A woman at risk is defined as a woman testing positive for BRCA1 or BRCA2 mutations, or one having a family history with: (a) one or more first or second degree relatives with ovarian cancer; (b) clusters of women relatives with breast cancer; or (c) nonpolyposis colorectal cancer.
- Charges made for an annual prostate-specific antigen test (PSA).
- Charges made for colorectal cancer screening, examinations and laboratory tests according to the most recently published guidelines and recommendations established by the American Cancer Society, in consultation with the American College of Gastroenterology and the American College of Radiology, if deemed appropriate by the Physician in consultation with the insured.

- Charges for the treatment of children's cancer for Dependent children who are: (a) diagnosed with cancer prior to their 26th birthday; and (b) enrolled in an approved clinical trial program for the treatment of children's cancer. Approved clinical trial programs are prescription drug clinical trial programs in the state of Georgia, as approved by the Federal Food and Drug Administration or the National Cancer Institute that will:
  - introduce new therapies and regimens which are more cost effective, and test them against standard therapies and regimens.
  - be certified by and will utilize the standards for acceptable protocols established by the Pediatric Oncology Group, Children's Cancer Group, or the Commissioner of Insurance.

  Covered Expenses will not include charges provided at no cost by the provider, or charges for treatment under the trial program which would not standardly be covered by CIGNA.
- Charges for appropriate counseling, medical services connected with surgical therapies, including vasectomy and tubal ligation.
- Charges made for laboratory services, radiation therapy and other diagnostic and therapeutic radiological procedures.
- Charges made for Family Planning, including medical history, physical exam, related laboratory tests, medical supervision in accordance with generally accepted medical practices, other medical services, information and counseling on contraception, implanted/injected contraceptives.
- Charges made for Routine Preventive Care including immunizations, not to exceed the maximum shown in the Schedule. Routine Preventive Care means health care assessments, wellness visits and any related services.

  In addition, Covered Expenses will include expenses incurred at any of the Approximate Age Intervals shown below for a Dependent child who is age 5 or less, for charges made for Child Wellness Services consisting of the following services delivered or supervised by a Physician, in keeping with prevailing medical standards:
  - a history;
  - physical examination;
  - development assessment;
  - anticipatory guidance; and
  - appropriate immunizations and laboratory tests;

  Excluding any charges for:
  - more than one visit to one provider for Child Wellness Services at each of the Approximate Age Intervals, up to a total of 12 visits for each Dependent child;
  - services for which benefits are otherwise provided under this Covered Expenses section;
  - services for which benefits are not payable according to the Expenses Not Covered section.

  It is provided that any Deductible that would otherwise apply will be waived for those Covered Expenses incurred for Child Wellness Services.

  Approximate Age Intervals are: Birth, 2 months, 4 months, 6 months, 9 months, 12 months, 15 months, 18 months, 2 years, 3 years, 4 years and 5 years.
- Charges for or in connection with the treatment of autism. Autism is defined as a developmental neurological disorder, usually appearing in the first three years of life, which affects normal brain functions and is manifested by compulsive, ritualistic behavior and severely impaired social interaction and communication skills.

- Surgical or nonsurgical treatment of TMJ Dysfunction.
- Charges made for hearing exams, including fitting of hearing aids.
- Hearing aids, including but not limited to semi-implantable hearing devices, audiant bone conductors and Bone Anchored Hearing Aids (BAHAs). A hearing aid is any device that amplifies sound.

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- Orthognathic surgery to repair or correct a severe facial deformity or disfigurement that orthodontics alone can not correct, provided:
  - the deformity or disfigurement is accompanied by a documented clinically significant functional impairment, and there is a reasonable expectation that the procedure will result in meaningful functional improvement; or
  - the orthognathic surgery is Medically Necessary as a result of tumor, trauma, disease or;
  - the orthognathic surgery is performed prior to age 19 and is required as a result of severe congenital facial deformity or congenital condition.

  Repeat or subsequent orthognathic surgeries for the same condition are covered only when the previous orthognathic surgery met the above requirements, and there is a high probability of significant additional improvement as determined by the utilization review Physician.

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Clinical Trials

- Charges made for routine patient services associated with cancer clinical trials approved and sponsored by the federal government. In addition the following criteria must be met:
  - the cancer clinical trial is listed on the NIH web site www.clinicaltrials.gov as being sponsored by the federal government;
  - the trial investigates a treatment for terminal cancer and: (1) the person has failed standard therapies for the disease; (2) cannot tolerate standard therapies for the disease; or (3) no effective nonexperimental treatment for the disease exists;
  - the person meets all inclusion criteria for the clinical trial and is not treated “off-protocol”;
  - the trial is approved by the Institutional Review Board of the institution administering the treatment; and
  - coverage will not be extended to clinical trials conducted at nonparticipating facilities if a person is eligible to participate in a covered clinical trial from a Participating Provider.

  Routine patient services do not include, and reimbursement will not be provided for:
  - the investigational service or supply itself;
  - services or supplies listed herein as Exclusions;
  - services or supplies related to data collection for the clinical trial (i.e., protocol-induced costs);
  - services or supplies which, in the absence of private health care coverage, are provided by a clinical trial sponsor or other party (e.g., device, drug, item or service supplied by manufacturer and not yet FDA approved) without charge to the trial participant.

Genetic Testing

- Charges made for genetic testing that uses a proven testing method for the identification of genetically-linked inheritable disease. Genetic testing is covered only if:
  - a person has symptoms or signs of a genetically-linked inheritable disease;

- it has been determined that a person is at risk for carrier status as supported by existing peer-reviewed, evidence-based, scientific literature for the development of a genetically-linked inheritable disease when the results will impact clinical outcome; or

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- the therapeutic purpose is to identify specific genetic mutation that has been demonstrated in the existing peer-reviewed, evidence-based, scientific literature to directly impact treatment options.

Pre-implantation genetic testing, genetic diagnosis prior to embryo transfer, is covered when either parent has an inherited disease or is a documented carrier of a genetically-linked inheritable disease.

Genetic counseling is covered if a person is undergoing approved genetic testing, or if a person has an inherited disease and is a potential candidate for genetic testing. Genetic counseling is limited to 3 visits per calendar year for both pre- and postgenetic testing.

Nutritional Evaluation and Counseling

- Charges made for nutritional evaluation and counseling when diet is a part of the medical management of a documented disease.

Internal Prosthetic/Medical Appliances

- Charges made for internal prosthetic/medical appliances that provide permanent or temporary internal functional supports for nonfunctional body parts are covered. Medically Necessary repair, maintenance or replacement of a covered appliance is also covered.

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Home Health Services

- Charges made for Home Health Services when you: (a) require skilled care; (b) are unable to obtain the required care as an ambulatory outpatient; and (c) do not require confinement in a Hospital or Other Health Care Facility.

  Home Health Services are provided only if CIGNA has determined that the home is a medically appropriate setting. If you are a minor or an adult who is dependent upon others for nonskilled care and/or custodial services (e.g., bathing, eating, toileting), Home Health Services will be provided for you only during times when there is a family member or care giver present in the home to meet your nonskilled care and/or custodial services needs.

  Home Health Services are those skilled health care services that can be provided during visits by Other Health Care Professionals. The services of a home health aide are covered when rendered in direct support of skilled health care services provided by Other Health Care Professionals. A visit is defined as a period of 2 hours or less. Home Health Services are subject to a maximum of 16 hours in total per day. Necessary consumable medical supplies and home infusion therapy administered or used by Other Health Care Professionals in providing Home Health Services are covered. Home Health Services do not include services by a person who is a member of your family or your Dependent's family or who normally resides in your house or your Dependent's house even if that person is an Other Health Care Professional. Skilled nursing services or private duty nursing services provided in the home are subject to the Home Health Services benefit terms, conditions and benefit limitations. Physical, occupational, and other Short-Term Rehabilitative Therapy services provided in the home are subject to the Home Health Services benefit limitations shown in the Schedule.

GM6000 05BPT104

Hospice Care Services

- Charges made for a person who has been diagnosed as having six months or fewer to live, due to Terminal Illness, for the following Hospice Care Services provided under a Hospice Care Program:
  - by a Hospice Facility for Bed and Board;
  - by a Hospice Care program for Services and Supplies;
  - by a Hospice Facility for services provided on an outpatient basis;
  - by a Physician for professional services;
  - by a Psychologist, social worker, family counselor or ordained minister for individual and family bereavement counseling;
  - for pain relief treatment, including drugs, medicines and medical supplies;
  - by an Other Health Care Facility for:
    - part-time or intermittent nursing care by or under the supervision of a Nurse;
    - part-time or intermittent services of an Other Health Care Professional;

GM6000 CM34 FLX124V38

    - physical, occupational and speech therapy;
    - medical supplies; drugs and medicines lawfully dispensed only on the written prescription of a Physician; and laboratory services; but only to the extent such charges would have been payable under the policy if the person had remained or been Confined in a Hospital or Hospice Facility.

The following charges for Hospice Care Services are not included as Covered Expenses:

- for the services of a person who is a member of your family or your Dependent's family or who normally resides in your house or your Dependent's house;
- for any period when you or your Dependent is not under the care of a Physician;
- for services or supplies not listed in the Hospice Care Program;
- for any curative or life-prolonging procedures;
- to the extent that any other benefits are payable for those expenses under the policy;
- for services or supplies that are primarily to aid you or your Dependent in daily living;

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Mental Health and Substance Abuse Services

Mental Health Services are services that are required to treat a disorder that impairs the behavior, emotional reaction or thought processes. In determining benefits payable, charges made for the treatment of any physiological conditions related to Mental Health will not be considered to be charges made for treatment of Mental Health.

Substance Abuse is defined as the psychological or physical dependence on alcohol or other mind-altering drugs that requires diagnosis, care, and treatment. In determining benefits payable, charges made for the treatment of any physiological conditions related to rehabilitation services for alcohol or drug abuse or addiction will not be considered to be charges made for treatment of Substance Abuse.

Inpatient Mental Health Services

Services that are provided by a Hospital while you or your Dependent is Confined in a Hospital for the treatment and evaluation of Mental Health. Inpatient Mental Health Services include Partial Hospitalization .

GM6000 INDEM9 V51

Outpatient Mental Health Services

Services of Providers who are qualified to treat Mental Health when treatment is provided on an outpatient basis, while you or your Dependent is not Confined in a Hospital, and is provided in an individual, group or Mental Health Intensive Outpatient Therapy Program. Covered services include, but are not limited to, outpatient treatment of conditions such as: anxiety or depression which interfere with daily functioning; emotional adjustment or concerns related to chronic conditions, such as psychosis or depression; emotional reactions associated with marital problems or divorce; child/adolescent problems of conduct or poor impulse control; affective disorders; suicidal or homicidal threats or acts; eating disorders; or acute exacerbation of chronic Mental Health conditions (crisis intervention and relapse prevention) and outpatient testing and assessment.

A Mental Health Intensive Outpatient Therapy Program consists of distinct levels or phases of treatment that are provided by a certified/licensed Mental Health program. Intensive Outpatient Therapy Programs provide a combination of individual, family and/or group therapy in a day, totaling nine or more hours in a week. Mental Health Intensive Outpatient Therapy Program services are exchanged with Outpatient Mental Health services at a rate of one visit of Mental Health Intensive Outpatient Therapy being equal to one visit of Outpatient Mental Health Services.

GM6000 INDEM10 V46

Inpatient Substance Abuse Rehabilitation Services

Services provided for rehabilitation, while you or your Dependent is Confined in a Hospital, when required for the diagnosis and treatment of abuse or addiction to alcohol and/or drugs. Inpatient Substance Abuse Services include Partial Hospitalization sessions.

Outpatient Substance Abuse Rehabilitation Services

Services provided for the diagnosis and treatment of abuse or addiction to alcohol and/or drugs, while you or your Dependent is not Confined in a Hospital, including outpatient rehabilitation in an individual, or a Substance Abuse Intensive Outpatient Therapy Program.

A Substance Abuse Intensive Outpatient Therapy Program consists of distinct levels or phases of treatment that are provided by a certified/licensed Substance Abuse program. Intensive Outpatient Therapy Programs provide a combination of individual, family and/or group therapy in a day, totaling nine, or more hours in a week. Substance Abuse Intensive Outpatient Therapy Program services are exchanged with Outpatient

Substance Abuse services at a rate of one visit of Substance Abuse Intensive Outpatient Therapy being equal to one visit of Outpatient Substance Abuse Rehabilitation Services.

GM6000 INDEM11 V70

Substance Abuse Detoxification Services

Detoxification and related medical ancillary services are provided when required for the diagnosis and treatment of addiction to alcohol and/or drugs. CIGNA will decide, based on the Medical Necessity of each situation, whether such services will be provided in an inpatient or outpatient setting.

Mental Health and Substance Abuse Exclusions

The following are specifically excluded from Mental Health and Substance Abuse Services:

- Any court ordered treatment or therapy, or any treatment or therapy ordered as a condition of parole, probation or custody or visitation evaluations unless Medically Necessary and otherwise covered under this policy or agreement.
- Treatment of disorders which have been diagnosed as organic mental disorders associated with permanent dysfunction of the brain.
- Developmental disorders, including but not limited to, developmental reading disorders, developmental arithmetic disorders, developmental language disorders or developmental articulation disorders.
- Counseling for activities of an educational nature.
- Counseling for borderline intellectual functioning.
- Counseling for occupational problems.
- Counseling related to consciousness raising.
- Vocational or religious counseling.
- I.Q. testing.
- Custodial care, including but not limited to geriatric day care.
- Psychological testing on children requested by or for a school system.
- Occupational/recreational therapy programs even if combined with supportive therapy for age-related cognitive decline.
- Residential Treatment Services.

GM6000 INDEM12 V48

Durable Medical Equipment

- Charges made for purchase or rental of Durable Medical Equipment that is ordered or prescribed by a Physician and provided by a vendor approved by CIGNA for use outside a Hospital or Other Health Care Facility. Coverage for repair, replacement or duplicate equipment is provided only when required due to anatomical change and/or reasonable wear and tear. All maintenance and repairs that result from a person's misuse are the person's responsibility. Coverage for Durable Medical Equipment is limited to the lowest-cost alternative as determined by the utilization review Physician.

  Durable Medical Equipment is defined as items which are designed for and able to withstand repeated use by more than one person; customarily serve a medical purpose; generally are not useful in the absence of Injury or Sickness; are appropriate for use in the home; and are not disposable. Such equipment includes, but is not limited to, crutches, hospital beds, respirators, wheel chairs, and dialysis machines.

  Durable Medical Equipment items that are not covered include but are not limited to those that are listed below:

  - **Bed Related Items:** bed trays, over the bed tables, bed wedges, pillows, custom bedroom equipment, mattresses, including nonpower mattresses, custom mattresses and posturepedic mattresses.
  - **Bath Related Items:** bath lifts, nonportable whirlpools, bathtub rails, toilet rails, raised toilet seats, bath benches, bath stools, hand held showers, paraffin baths, bath mats, and spas.
  - **Chairs, Lifts and Standing Devices:** computerized or gyroscopic mobility systems, roll about chairs, geriatric chairs, hip chairs, seat lifts (mechanical or motorized), patient lifts (mechanical or motorized – manual hydraulic lifts are covered if patient is two-person transfer), and auto tilt chairs.
  - **Fixtures to Real Property:** ceiling lifts and wheelchair ramps.
  - **Car/Van Modifications**.
  - **Air Quality Items:** room humidifiers, vaporizers, air purifiers and electrostatic machines.
  - **Blood/Injection Related Items:** blood pressure cuffs, centrifuges, nova pens and needleless injectors.
  - **Other Equipment:** heat lamps, heating pads, cryounits, cryotherapy machines, electronic-controlled therapy units, ultraviolet cabinets, sheepskin pads and boots, postural drainage board, AC/DC adaptors, enuresis alarms, magnetic equipment, scales (baby and adult), stair gliders, elevators, saunas, any exercise equipment and diathermy machines.

GM6000 05BPT3

External Prosthetic Appliances and Devices

- Charges made or ordered by a Physician for: the initial purchase and fitting of external prosthetic appliances and devices available only by prescription which are necessary for the alleviation or correction of Injury, Sickness or congenital defect.

  External prosthetic appliances and devices shall include prostheses/prosthetic appliances and devices, orthoses and orthotic devices; braces; and splints.

Prostheses/Prosthetic Appliances and Devices

Prostheses/prosthetic appliances and devices are defined as fabricated replacements for missing body parts. Prostheses/prosthetic appliances and devices include, but are not limited to:

- basic limb prostheses;
- terminal devices such as hands or hooks; and
- speech prostheses.

Essential External Prosthetic Appliance

Upper and Lower limb prosthetic devices and associated components

Non Essential External Prosthetic Appliance

(Prosthetics not associated with upper or lower limbs) such as Facial-Orbital (eyes), Hemifacial/Midfacial/Nasal (nose), Auricular (ear), Breast (Post mastectomy), Penile, etc.

Orthoses and Orthotic Devices

Orthoses and orthotic devices are defined as orthopedic appliances or apparatuses used to support, align, prevent or correct deformities. Coverage is provided for custom foot orthoses and other orthoses as follows:

- Nonfoot orthoses – only the following nonfoot orthoses are covered:
  - rigid and semirigid custom fabricated orthoses;
  - semirigid prefabricated and flexible orthoses; and
  - rigid prefabricated orthoses including preparation, fitting and basic additions, such as bars and joints.
- Custom foot orthoses – custom foot orthoses are only covered as follows:
  - for persons with impaired peripheral sensation and/or altered peripheral circulation (e.g. diabetic neuropathy and peripheral vascular disease);
  - when the foot orthosis is an integral part of a leg brace and is necessary for the proper functioning of the brace;
  - when the foot orthosis is for use as a replacement or substitute for missing parts of the foot (e.g. amputated toes) and is necessary for the alleviation or correction of Injury, Sickness or congenital defect; and
  - for persons with neurologic or neuromuscular condition (e.g. cerebral palsy, hemiplegia, spina bifida) producing spasticity, malalignment, or pathological positioning of the foot and there is reasonable expectation of improvement.

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The following are specifically excluded orthoses and orthotic devices:

- prefabricated foot orthoses;
- cranial banding and/or cranial orthoses. Other similar devices are excluded except when used postoperatively for synostotic plagiocephaly. When used for this indication, the cranial orthosis will be subject to the limitations and maximums of the External Prosthetic Appliances and Devices benefit;
- orthosis shoes, shoe additions, procedures for foot orthopedic shoes, shoe modifications and transfers;
- orthoses primarily used for cosmetic rather than functional reasons; and
- orthoses primarily for improved athletic performance or sports participation.

Braces

A Brace is defined as an orthosis or orthopedic appliance that supports or holds in correct position any movable part of the body and that allows for motion of that part.

The following braces are specifically excluded: Copes scoliosis braces.

Splints

A Splint is defined as an appliance for preventing movement of a joint or for the fixation of displaced or movable parts.

Coverage for replacement of external prosthetic appliances and devices is limited to the following:

- Replacement due to regular wear. Replacement for damage due to abuse or misuse by the person will not be covered.
- Replacement will be provided when anatomic change has rendered the external prosthetic appliance or device ineffective. Anatomic change includes significant weight gain or loss, atrophy and/or growth.
- Coverage for replacement is limited as follows:
  - No more than once every 24 months for persons 19 years of age and older.
  - No more than once every 12 months for persons 18 years of age and under.
  - Replacement due to a surgical alteration or revision of the site.

The following are specifically excluded external prosthetic appliances and devices:

- External and internal power enhancements or power controls for prosthetic limbs and terminal devices; and
- Myoelectric prostheses peripheral nerve stimulators.

GM6000 05BPT5

Short-Term Rehabilitative Therapy

Short-term Rehabilitative Therapy that is part of a rehabilitation program, including physical, speech, occupational, cognitive, osteopathic manipulative, cardiac rehabilitation and pulmonary rehabilitation therapy, when provided in the most medically appropriate setting.

The following limitations apply to Short-term Rehabilitative Therapy:

- Each therapy is limited to 40 days.
- Children (up to age 19) with congenital anomalies that required surgical correction may receive Physical Therapy services beyond 40 days. Case Management enrollment is required and must meet medical necessity criteria.
- Occupational therapy is provided only for purposes of enabling persons to perform the activities of daily living after an Illness or Injury or Sickness.

Short-term Rehabilitative Therapy services that are not covered include but are not limited to:

- Sensory integration therapy, group therapy; treatment of dyslexia; behavior modification or myofunctional therapy for dysfluency, such as stuttering or other involuntarily acted conditions without evidence of an underlying medical condition or neurological disorder;
- Treatment for functional articulation disorder such as correction of tongue thrust, lisp, verbal apraxia or swallowing dysfunction that is not based on an underlying diagnosed medical condition or Injury; and
- Maintenance or preventive treatment consisting of routine, long-term or non-Medically Necessary care provided to prevent recurrence or to maintain the patient's current status.

These services will also include habilitative services (including developmental speech therapy) for the treatment of children under age 19 with congenital and genetic birth defects to enhance the child's ability to function. Congenital and genetic birth defects are described as a defect existing at or from birth, including a hereditary defect as well as autism or an autism spectrum disorder; and cerebral palsy. Otherwise, excludes therapy to improve speech skills that have not fully developed (except when speech is not fully developed in

children due to an underlying disease or malformation that prevented speech development); therapy intended to maintain speech communication; or therapy not restorative in nature.

Services that are provided by a chiropractic Physician are not covered.

These services include the conservative management of acute neuromusculoskeletal conditions through manipulation and ancillary physiological treatment rendered to restore motion, reduce pain and improve function.

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Chiropractic Care Services

Charges made for diagnostic and treatment services utilized in an office setting by chiropractic Physicians. Chiropractic treatment includes the conservative management of acute neuromusculoskeletal conditions through manipulation and ancillary physiological treatment rendered to specific joints to restore motion, reduce pain, and improve function. For these services you have direct access to qualified chiropractic Physicians.

The following limitation applies to Chiropractic Care Services:

- Occupational therapy is provided only for purposes of enabling persons to perform the activities of daily living after an Injury or Sickness.

Chiropractic Care services that are not covered include but are not limited to:

- services of a chiropractor which are not within his scope of practice, as defined by state law;
- charges for care not provided in an office setting;
- maintenance or preventive treatment consisting of routine, longterm or non-Medically Necessary care provided to prevent recurrence or to maintain the patient's current status; and
- vitamin therapy.

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Transplant Services (All Transplant Services require pre-authorization)

Note: Contact 1-800-633-8519 (Actives) or 1-800-942-6724 (Retirees) for pre-authorization and case management services for organ transplant services.

- Charges made for human organ and tissue transplant services which include solid organ and bone marrow/stem cell procedures at designated facilities throughout the United States or its territories. This coverage is subject to the following conditions and limitations.

  Transplant services include the recipient's medical, surgical and Hospital services; inpatient immunosuppressive medications; and costs for organ or bone marrow/stem cell procurement. Transplant services are covered only if they are required to perform any of the following human to human organ or tissue transplants: allogeneic bone marrow/stem cell, autologous bone marrow/stem cell, cornea, heart/lung, kidney, kidney/pancreas, liver, lung, pancreas or intestine which includes small bowel, liver or multiple viscera.

  All Transplant services, other than cornea, are payable at 100% when received at CIGNA LIFESOURCE Transplant Network® Facilities. Cornea transplants are not covered at CIGNA LIFESOURCE Transplant Network® facilities. Transplant services, including cornea, when received from Participating Provider facilities other than CIGNA LIFESOURCE Transplant Network® facilities are payable at the In-Network level. **Transplant services received at any other facilities are not covered.**

  Coverage for organ procurement costs are limited to costs directly related to the procurement of an organ, from a cadaver or a live donor. Organ procurement costs shall consist of surgery necessary for organ removal, organ transportation and the transportation, hospitalization and surgery of a live donor. Compatibility testing undertaken prior to procurement is covered if Medically Necessary. Costs related to the

search for, and identification of a bone marrow or stem cell donor for an allogeneic transplant are also covered.

Transplant Travel Services

Charges made for reasonable travel expenses incurred by you in connection with a preapproved organ/tissue transplant are covered subject to the following conditions and limitations. Transplant travel benefits are not available for cornea transplants. Benefits for transportation, lodging and food are available to you only if you are the recipient of a preapproved organ/tissue transplant from a designated CIGNA LIFESOURCE Transplant Network® facility. The term recipient is defined to include a person receiving authorized transplant related services during any of the following: (a) evaluation, (b) candidacy, (c) transplant event, or (d) post-transplant care. Travel expenses for the person receiving the transplant will include charges for: transportation to and from the transplant site (including charges for a rental car used during a period of care at the transplant facility); lodging while at, or traveling to and from the transplant site; and food while at, or traveling to and from the transplant site.

In addition to your coverage for the charges associated with the items above, such charges will also be considered covered travel expenses for one companion to accompany you. The term companion includes your spouse, a member of your family, your legal guardian, or any person not related to you, but actively involved as your caregiver.

The following are specifically excluded travel expenses:

Travel costs incurred due to travel within 60 miles of your home; laundry bills; telephone bills; alcohol or tobacco products; and charges for transportation that exceed coach class rates.

These benefits are only available when the covered person is the recipient of an organ transplant. No benefits for travel expenses are available when the covered person is a donor.

GM6000 05BPT7 V7

Breast Reconstruction and Breast Prostheses

- Charges made for reconstructive surgery following a mastectomy; benefits include: (a) surgical services for reconstruction of the breast on which surgery was performed; (b) surgical services for reconstruction of the nondiseased breast to produce symmetrical appearance; (c) postoperative breast prostheses; and (d) mastectomy bras and external prosthetics, limited to the lowest cost alternative available that meets external prosthetic placement needs. During all stages of mastectomy, treatment of physical complications, including lymphedema therapy, are covered.

Reconstructive Surgery

- Charges made for reconstructive surgery or therapy to repair or correct a severe physical deformity or disfigurement which is accompanied by functional deficit; (other than abnormalities of the jaw or conditions related to TMJ disorder) provided that: (a) the surgery or therapy restores or improves function; (b) reconstruction is required as a result of Medically Necessary, noncosmetic surgery; or (c) the surgery or therapy is performed prior to age 19 and is required as a result of the congenital absence or agenesis (lack of formation or development) of a body part. Repeat or subsequent surgeries for the same condition are covered only when there is the probability of significant additional improvement as determined by the utilization review Physician.

GM6000 05BPT2 V2

Prescription Drug Benefits The Schedule
For You and Your Dependents
This plan provides Prescription Drug benefits for Prescription Drugs and Related Supplies provided by Pharmacies as shown in this Schedule. Prescription drugs have a three (3) tier structure with a minimum and maximum Coinsurance amount paid by the member. To receive Prescription Drug Benefits, you and your Dependents may be required to satisfy the deductible and/or pay a portion of the Covered Expenses for Prescription Drugs and Related Supplies for each 30-day supply at a retail pharmacy, each 90-day supply at a participating retail pharmacy or each 90-day supply received through CIGNA's mail order pharmacy, CIGNA Home Delivery. That portion is the Coinsurance.
Coinsurance The term Coinsurance means the percentage of charges for Covered Expenses that an insured person is required to pay under the plan.
Deductibles Deductibles are expenses to be paid by you or your Dependent for Covered Prescription Drugs. These Deductibles are in addition to any coinsurance. Once the Deductible maximum shown in The Schedule has been reached, you and your family need not satisfy any further Prescription Drug Deductible for the rest of the plan year.

BENEFIT HIGHLIGHTS	PARTICIPATING PHARMACY	Non-PARTICIPATING PHARMACY
Deductibles and Out-of-Pocket Maximums for Active Employees and Retirees		
You	Refer to the Medical Benefits Schedule	Not applicable
You+ Spouse	Refer to the Medical Benefits Schedule	Not applicable
You + Child(ren)	Refer to the Medical Benefits Schedule	Not applicable
You + Family	Refer to the Medical Benefits Schedule	Not applicable
Prescription Drugs		
Generic* drugs on the Prescription Drug List	80% per prescription order or refill after the plan deductible has been met Minimum $10, Maximum $100 up to a 30-day supply Minimum $30, Maximum $300 up to a 90-day supply at retail pharmacy Minimum $25, Maximum $250 up to a 90-day supply at mail order pharmacy	Not Covered
Brand-Name* drugs designated as preferred on the Prescription Drug List	80% per prescription order or refill after the plan deductible has been met Minimum $10, Maximum $100 up to a 30-day supply Minimum $30, Maximum $300 up to a 90-day supply at retail pharmacy Minimum $25, Maximum $250 up to a 90-day supply at mail order pharmacy	Not Covered

BENEFIT HIGHLIGHTS	PARTICIPATING PHARMACY	Non-PARTICIPATING PHARMACY
Brand-Name* drugs with a Generic equivalent and drugs designated as non-preferred on the Prescription Drug List	80% per prescription order or refill after the plan deductible has been met Minimum $10, Maximum $100 up to a 30-day supply Minimum $30, Maximum $300 up to a 90-day supply at retail pharmacy Minimum $25, Maximum $250 up to a 90-day supply at mail order pharmacy	Not Covered
*Designated as per generally-accepted industry sources and adopted by CIGNA		
Note: If the physician does not write DAW on the prescription, but the member desires and/or requests the brand drug, when a generic is available, the member pays the applicable brand coinsurance plus the difference in cost between the brand and generic if a generic equivalent is available (up to the cost of the brand-name drug).		

Prescription Drug Benefits

For You and Your Dependents

Covered Expenses

If you or any one of your Dependents, while insured for Prescription Drug Benefits, incurs expenses for charges made by a Pharmacy, for Medically Necessary Prescription Drugs or Related Supplies ordered by a Physician, CIGNA will provide coverage for those expenses as shown in the Schedule. Coverage also includes Medically Necessary Prescription Drugs and Related Supplies dispensed for a prescription issued to you or your Dependents by a licensed dentist for the prevention of infection or pain in conjunction with a dental procedure.

When you or a Dependent is issued a prescription for Medically Necessary Prescription Drugs or Related Supplies as part of the rendering of Emergency Services and that prescription cannot reasonably be filled by a Participating Pharmacy, the prescription will be covered by CIGNA, as if filled by a Participating Pharmacy.

CIGNA Home Delivery

You and your Dependents now have the option to obtain a 90-day supply of prescription drugs through CIGNA's mail order pharmacy, CIGNA Home Delivery. When you order your prescriptions through CIGNA Home Delivery, your prescription will be mailed to you and you will pay a lower contracted rate with lower minimums and maximums than when you purchase a 90-day supply through a retail pharmacy. The following example illustrates your savings.

	90-day Supply at Retail	90-day Supply at CIGNA Home Delivery	Savings
Preferred Brand Drug	$30	$25	$5 per 90-day supply $20 annually

For more information on the CIGNA Mail Order option, call our Customer Care number on your ID card.

Custom 90-Day Retail Network

Some retail pharmacies in our network may agree to accept the CIGNA mail order, CIGNA Home Delivery cost-sharing amount you pay to obtain up to a 90-day supply of medications. Other retail pharmacies may not agree to accept the mail order cost sharing amount for the 90-day supply of medications. In this case you will be responsible for the difference in price. Your pharmacy directory lists which pharmacies in our network can give you a 90-day supply of medications at the lower mail order cost share.

For more information on the 90-day Retail Network, call the Customer Care number on your ID card for more information.

Specialty Medications

State Health Benefit Plan members are required to use CIGNA Home Delivery to receive up to a 30-day supply of specialty medications. All specialty medications will be exclusively available through CIGNA Home Delivery Pharmacy. You will be allowed two fills at a retail Pharmacy, then any additional fills must be obtained through CIGNA Home Delivery. Please note: If you exceed the allowed number of fills and you choose to fill any of the specialty medications at retail you will be required to pay the full price with no coverage under your prescription drug plan.

For more information about Specialty Medications, please call the Customer Care number on your ID card.

Limitations

Each Prescription Order or refill shall be limited as follows:

- up to a consecutive 30-day supply, at a retail Pharmacy, unless limited by the drug manufacturer's packaging;
- up to a consecutive 90-day supply for a maintenance medication, at a participating (or in-network) retail Pharmacy, unless limited by the drug manufacturer's packaging; or
- up to a consecutive 90-day supply for a maintenance medication, through CIGNA Home Delivery, unless limited by the drug manufacturer's packaging; or
- up to a consecutive 30-day supply for a **specialty** maintenance medication, through CIGNA Home Delivery, unless limited by the drug manufacturer's packaging; or
- to a dosage and/or dispensing limit as determined by the P&T Committee.

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Coverage for certain Prescription Drugs and Related Supplies requires your Physician to obtain authorization prior to prescribing. If the request is approved, your Physician will receive confirmation. The authorization will be processed in our claim system to allow you to have coverage for those Prescription Drugs or Related Supplies. The length of the authorization will depend on the diagnosis and Prescription Drugs or Related Supplies. When your Physician advises you that coverage for the Prescription Drugs or Related Supplies has been approved, you should contact the Pharmacy to fill the prescription(s).

If the request is denied, your Physician and you will be notified that coverage for the Prescription Drugs or Related Supplies is not authorized.

If you disagree with a coverage decision, you may appeal that decision in accordance with the provisions of the Policy, by submitting a written request stating why the Prescription Drugs or Related Supplies should be covered.

Written appeals and inquiries related to the Prescription Drug Program should be directed to:

CIGNA
P.O. Box 188050
Chattanooga, TN 37422-8050

If you have questions about a specific prior authorization request, you should call Member Services at 1-800-633-8519 (Actives) or 1-800-942-6724 (Retirees). For details regarding how to file an appeal, please refer to the section titled, When You Have a Complaint or an Appeal on a following page.

Note: Tier status will not be overridden or changed on an individual basis.

All drugs newly approved by the Food and Drug Administration (FDA) are designated as either non-Preferred or non-Prescription Drug List drugs until the P & T Committee clinically evaluates the Prescription Drug for a different designation.

In addition, prescription drugs that have an equally effective and less costly generic-equivalent are designated as non-Preferred drugs.

Prescription Drugs that represent an advance over available therapy according to the FDA will be reviewed by the P&T Committee within six months after FDA approval. Prescription Drugs that appear to have therapeutic qualities similar to those of an already marketed drug according to the FDA, will not be reviewed by the P&T Committee for at least six months after FDA approval. In the case of compelling clinical data, an ad hoc group will be formed to make an interim decision on the merits of a Prescription Drug.

Your Payments

Coverage for Prescription Drugs and Related Supplies purchased at a Pharmacy is subject to the Coinsurance shown in the Prescription Drug Benefits Schedule.

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Prescription Drug Program Exclusions

No payment will be made for the following expenses:

- Drugs available over the counter that do not require a prescription by federal or state law, except that certain over-the-counter drugs may be covered as required by the Patient Protection Affordable Care Act (PPACA). See page 149 for details.
- Any drug that is a pharmaceutical alternative to an over-the-counter drug other than insulin.
- A drug class in which at least one of the drugs is available over the counter and the drugs in the class are deemed to be therapeutically equivalent as determined by the P&T Committee.
- Injectable infertility drugs and any injectable drugs that require Physician supervision and are not typically considered self-administered drugs. The following are examples of Physician supervised drugs: Injectables used to treat hemophilia and RSV (respiratory syncytial virus), chemotherapy injectables and endocrine and metabolic agents.
- Any drugs that are experimental or investigational as described under the Medical "Exclusions" section of your certificate.
- Food and Drug Administration (FDA) approved drugs used for purposes other than those approved by the FDA unless the drug is recognized for the treatment of the particular indication in one of the standard reference compendia (The United States Pharmacopeia Drug Information, The American Medical Association Drug Evaluations; or The American Hospital Formulary Service Drug Information) or in medical literature. Medical literature means scientific studies published in a peer-reviewed national professional medical journal.
- Prescription and nonprescription supplies (such as ostomy supplies), devices, and appliances other than Related Supplies.
- Implantable contraceptive products.
- Any fertility drug.
- Dietary supplements.
- Drugs used for cosmetic purposes such as drugs used to reduce wrinkles, drugs to promote hair growth as well as drugs used to control perspiration and fade cream products.
- Diet pills or appetite suppressants (anorectics).
- Prescription smoking cessation products unless actively engaged in the telephonic tobacco cessation program.
- Immunization agents, biological products for allergy immunization, biological sera, blood, blood plasma and other blood products or fractions and medications used for travel prophylaxis.
- Replacement of Prescription Drugs and Related Supplies due to loss or theft.
- Drugs used to enhance athletic performance.
- Drugs which are to be taken by or administered to you while you are a patient in a licensed Hospital, Skilled Nursing Facility, Rehabilitation Hospital (Long Term Acute Care Facility), rest home or similar institution which operates on its premises or allows to be operated on its premises a facility for dispensing pharmaceuticals.

- Prescriptions more than one year from the original date of issue.
- Other limitations are shown in the Medical "Exclusions" section.

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Reimbursement/Filing a Claim

When you or your Dependents purchase your Prescription Drugs or Related Supplies through a retail Participating Pharmacy, you pay any applicable Coinsurance shown in the Schedule at the time of purchase. You do not need to file a claim form for Participating Retail Pharmacies.

Reimbursement for Non-Participating Pharmacies will be limited to the Participating Pharmacy contracted rate.

If you or your Dependents purchase your Prescription Drugs or Related Supplies through a non-Participating Pharmacy, you pay the full cost at the time of purchase. You must submit a claim form to be reimbursed.

Visit www.dch.georgia.gov/shbp or myCIGNA.com to obtain the appropriate claim form.

Coordination of Benefits With Prescription Drugs

If your spouse or a dependent has primary coverage from another health plan, prescription drug benefits provided by the State Health Benefit Plan (SHBP) will be coordinated with the other insurance carrier(s). This means you must first use your primary insurance plan when you pay for your prescription(s). To request a secondary payment from CIGNA at the time of purchase you can request the Pharmacist to electronically file SHBP secondary. By mail you can send a claim form and attach a copy of the Explanation of Benefits (EOB) form from the primary plan and the pharmacy receipt. You can obtain a claim form at myCIGNA.com or www.dch.georgia.gov/shbp.

Secondary payments are subject to network allowed amounts for covered drugs. Under the SHBP plan, you will be responsible for the appropriate coinsurance amounts reflected in the Prescription Drug Benefits Schedule. In the event that your primary plan coinsurance amounts/copays are less than the coinsurance amounts under the SHBP plan, no secondary payment will be allowed. Please contact CIGNA at the Customer Care number on your State Health Benefit Plan ID card for more details.

If you have coverage under two State Health Benefit Plan contracts (cross-coverage) prescription drug benefits provided by the State Health Benefit Plan will not be coordinated.

What should I do if I use a self-administered injectable medication?

You may have coverage for self-administered injectable medications through your pharmacy benefit plan or under your medical benefits.

Please call our Customer Care number on your ID card to determine whether or not a medication is covered as a self-administered injectable under your pharmacy or medical benefits.

How do I obtain a supply of my medications before I go on vacation?

Vacation overrides are allowed for members to have up to a 3 month supply of medication in their possession. If someone is leaving the country for an extended period of time for work or a student studying abroad, we will allow multiple months to process up to one year. This does not apply to extended vacations. If the member's eligibility status will change as a result of working or studying abroad the member is not eligible for an extended override.

You may also locate a network pharmacy at your vacation destination through the Internet at myCIGNA.com or by calling the Customer Care number on your ID card.

How do I access updated information about my pharmacy benefit?

Since the Prescription Drug List may change periodically, we encourage you to visit myCIGNA.com or please call our Customer Care number on your ID card for more current information.

Log on to myCIGNA.com for the following pharmacy resources and tools:

- Pharmacy benefit and coverage information.
- Possible lower-cost medication alternatives.
- A list of medications based on a specific medical condition.
- Medication interactions and side effects, etc.
- Locate a participating retail pharmacy by zip code.
- Review your prescription history.

What if I still have questions?

Please call our Customer Care number on your ID card. Representatives are available to assist you 24 hours a day, except Thanksgiving and Christmas.

GM6000 PHARM94 V17

CIGNA VISION

The Schedule

For You and Your Dependents

Benefits Include:

Routine Eye Examinations – One vision and eye health evaluation including but not limited to eye health examination, dilation, refraction and prescription for glasses.

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Routine Eye Examinations Limited to one exam, including refraction, every 24 months	100% coverage	In-Network coverage only

CIGNA Vision Benefits

Covered Expenses

CIGNA will pay for covered services incurred by you and your eligible Dependents subject to: frequency limits; benefit maximums; cost sharing provisions; and limitations as set forth in the Schedule of Vision Benefits.

GM6000 VISION4

Expenses Not Covered

Covered Expenses will not include, and no payment will be made for:

- Orthoptic or vision training and any associated supplemental testing.
- Spectacle lens treatments, “add ons”, or lens coatings not shown as covered in the Schedule.
- Two pair of glasses, in lieu of bifocals or trifocals.
- Prescription sunglasses.
- Medical or surgical treatment of the eyes.
- Any eye examination, or any corrective eyewear, required by an employer as a condition of employment.
- Magnification or low vision aids.
- Any prescription or non-prescription eyeglasses, lenses, or contact lenses.
- Safety glasses or lenses required for employment.
- VDT (video display terminal)/ computer eyeglass benefit.
- Charges in excess of the Maximum Reimbursable Charge for the Service or Materials.
- Charges incurred after the Policy ends or the Insured's coverage under the Policy ends, except as stated in the Policy.
- Experimental or non-conventional treatment or device.
- High Index lenses of any material type.
- For or in connection with experimental procedures or treatment methods not approved by the American Optometric Association or the appropriate vision specialty society.

Other Limitations are shown in the "General Limitation and Exclusions" section.

GM6000 VISION5 V1

General Limitations and Exclusions

Applicable to All Coverages

Additional coverage limitations determined by plan or provider type are shown in the Schedule. Payment for the following is specifically excluded from this plan:

- Expenses for supplies, care, treatment, or surgery that are not Medically Necessary.
- To the extent that you or any one of your Dependents is in any way paid or entitled to payment for those expenses by or through a public program, other than Medicaid.
- To the extent that payment is unlawful where the person resides when the expenses are incurred.
- Charges made by a Hospital owned or operated by or which provides care or performs services for, the United States Government, if such charges are directly related to a military-service-connected Injury or Sickness.
- For or in connection with an Injury or Sickness which is due to war, declared or undeclared.
- Charges which you are not obligated to pay or for which you are not billed or for which you would not have been billed except that they were covered under this plan.
- Assistance in the activities of daily living, including but not limited to eating, bathing, dressing or other Custodial Services or self-care activities, homemaker services and services primarily for rest, domiciliary or convalescent care.
- For or in connection with experimental, investigational or unproven services.

  Experimental, investigational and unproven services are medical, surgical, diagnostic, psychiatric, substance abuse or other health care technologies, supplies, treatments, procedures, drug therapies or devices that are determined by the utilization review Physician to be:

  - Not demonstrated, through existing peer-reviewed, evidence-based, scientific literature to be safe and effective for treating or diagnosing the condition or sickness for which its use is proposed;
  - Not approved by the U.S. Food and Drug Administration (FDA) or other appropriate regulatory agency to be lawfully marketed for the proposed use;
  - The subject of review or approval by an Institutional Review Board for the proposed use except as provided in the “Clinical Trials” section of this plan; or
  - The subject of an ongoing phase I, II or III clinical trial, except as provided in the “Clinical Trials” section of this plan.
- Cosmetic surgery and therapies. Cosmetic surgery or therapy is defined as surgery or therapy performed to improve or alter appearance or self-esteem or to treat psychological symptomatology or psychosocial complaints related to one’s appearance.
- Regardless of clinical indication for gynecomastia surgeries; abdominoplasty/panniculectomy; rhinoplasty; redundant skin surgery; removal of skin tags; acupressure; craniosacral/cranial therapy; dance therapy; movement therapy; applied kinesiology; rolfing; prolotherapy; and extracorporeal shock wave lithotripsy (ESWL) for musculoskeletal and orthopedic conditions.
- For or in connection with treatment of the teeth or periodontium unless such expenses are incurred for: (a) charges made for a continuous course of dental treatment started within six months of an Injury to sound natural teeth; (b) charges made by a Hospital for Bed and Board or Necessary Services and Supplies; or (c) charges made by a Free-Standing Surgical Facility or the outpatient department of a Hospital in connection with surgery.

- For medical and surgical services, initial and repeat, intended for the treatment or control of obesity including clinically severe (morbid) obesity, including: medical and surgical services to alter appearances or physical changes that are the result of any surgery performed for the management of obesity or clinically severe (morbid) obesity; and weight loss programs or treatments, whether prescribed or recommended by a Physician or under medical supervision.
- Unless otherwise covered in this plan, for reports, evaluations, physical examinations, or hospitalization not required for health reasons including, but not limited to, employment, insurance or government licenses, and court-ordered, forensic or custodial evaluations.
- Court-ordered treatment or hospitalization, unless such treatment is prescribed by a Physician and listed as covered in this plan.
- Infertility services including infertility drugs, surgical or medical treatment programs for infertility, including in vitro fertilization, gamete intrafallopian transfer (GIFT), zygote intrafallopian transfer (ZIFT), variations of these procedures, and any costs associated with the collection, washing, preparation or storage of sperm for artificial insemination (including donor fees). Cryopreservation of donor sperm and eggs are also excluded from coverage.
- Reversal of male and female voluntary sterilization procedures.
- Transsexual surgery including medical or psychological counseling and hormonal therapy in preparation for, or subsequent to, any such surgery.
- Any medications, drugs, services or supplies for the treatment of male or female sexual dysfunction such as, but not limited to, treatment of erectile dysfunction (including penile implants), anorgasmy, and premature ejaculation.
- Medical and Hospital care and costs for the infant child of a Dependent, unless this infant child is otherwise eligible under this plan.
- Nonmedical counseling or ancillary services, including but not limited to Custodial Services, education, training, vocational rehabilitation, behavioral training, biofeedback, neurofeedback, hypnosis, sleep therapy, employment counseling, back school, return to work services, work hardening programs, driving safety, and services, training, educational therapy or other nonmedical ancillary services for the treatment of learning disabilities, developmental delays, autism or mental retardation. Nonmedical ancillary services DOES NOT include services such as physical therapy, speech therapy and occupational therapy.
- Behavioral therapies that are considered experimental, investigational or unproven are excluded and are non-covered services for treatment of any condition.
- Therapy or treatment intended primarily to improve or maintain general physical condition or for the purpose of enhancing job, school, athletic or recreational performance, including but not limited to routine, long term, or maintenance care which is provided after the resolution of the acute medical problem and when significant therapeutic improvement is not expected.
- Consumable medical supplies other than ostomy supplies and urinary catheters. Excluded supplies include, but are not limited to bandages and other disposable medical supplies, skin preparations and test strips, except as specified in the “Home Health Services” or “Breast Reconstruction and Breast Prostheses” sections of this plan.
- Private Hospital rooms and/or private duty nursing except as provided under the Home Health Services provision.
- Personal or comfort items such as personal care kits provided on admission to a Hospital, television, telephone, newborn infant photographs, complimentary meals, birth announcements, and other articles which are not for the specific treatment of an Injury or Sickness.

- Artificial aids including, but not limited to, corrective orthopedic shoes, arch supports, elastic stockings, garter belts, corsets, dentures and wigs, unless provided for hair loss as a result of cancer treatment/chemotherapy.
- Aids or devices that assist with nonverbal communications, including but not limited to communication boards, prerecorded speech devices, laptop computers, desktop computers, Personal Digital Assistants (PDAs), Braille typewriters, visual alert systems for the deaf and memory books.
- Medical benefits for eyeglasses, contact lenses or examinations for prescription or fitting thereof, except that Covered Expenses will include the purchase of the first pair of eyeglasses, lenses, frames or contact lenses that follows keratoconus or cataract surgery.
- Charges made for eye exercises and for surgical treatment for the correction of a refractive error, including radial keratotomy, when eyeglasses or contact lenses may be worn.
- All noninjectable prescription drugs, injectable prescription drugs that do not require Physician supervision and are typically considered self-administered drugs, nonprescription drugs, and investigational and experimental drugs, except as provided in this plan.
- Routine foot care, including the paring and removing of corns and calluses or trimming of nails. However, services associated with foot care for diabetes and peripheral vascular disease are covered when Medically Necessary.
- Membership costs or fees associated with health clubs, weight loss programs and smoking cessation programs.
- Genetic screening or pre-implantations genetic screening. General population-based genetic screening is a testing method performed in the absence of any symptoms or any significant, proven risk factors for genetically linked inheritable disease.
- Dental implants, unless provided as a result of damage from radiation or chemotherapy treatment and prior approved by CIGNA.
- Fees associated with the collection or donation of blood or blood products, except for autologous donation in anticipation of scheduled services where in the utilization review Physician's opinion the likelihood of excess blood loss is such that transfusion is an expected adjunct to surgery.
- Blood administration for the purpose of general improvement in physical condition.
- Cost of biologicals that are immunizations or medications for the purpose of travel, or to protect against occupational hazards and risks.
- Cosmetics, dietary supplements and health and beauty aids.
- Nutritional supplements and formulae except for infant formula needed for the treatment of inborn errors of metabolism.
- Medical treatment for a person age 65 or older, who is covered under this plan as a retiree, or their Dependent, when payment is denied by the Medicare plan because treatment was received from a nonparticipating provider.
- Medical treatment when payment is denied by a Primary Plan because treatment was received from a nonparticipating provider.
- For or in connection with an Injury or Sickness arising out of, or in the course of, any employment for wage or profit.
- Telephone, e-mail, and Internet consultations, and telemedicine.
- Massage therapy.
- For charges which would not have been made if the person had no insurance.
- To the extent that they are more than Maximum Reimbursable Charges.

- Charges made by any covered provider who is a member of your family or your Dependent's family.
- To the extent of the exclusions imposed by any certification requirement shown in this plan.

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GM6000 05BPT105
GM6000 06BNR2V2
GM6000 06BNR2 V88

Coordination of Benefits

This section applies if you or any one of your Dependents is covered under more than one non Medicare Advantage Plan and determines how benefits payable from all such non Medicare Advantage Plans will be coordinated. You should file all claims with each Plan.

Definitions

For the purposes of this section, the following terms have the meanings set forth below:

Plan

Any of the following that provides benefits or services for medical care or treatment:

(1) Group insurance and/or group-type coverage, whether insured or self-insured which neither can be purchased by the general public, nor is individually underwritten, including closed panel coverage.

(2) Coverage under Medicare and other governmental benefits as permitted by law, excepting Medicaid and Medicare supplement policies; or Workers' Compensation policies.

(3) Medical benefits coverage of group, group-type, and individual automobile contracts.

Each Plan or part of a Plan which has the right to coordinate benefits will be considered a separate Plan.

Closed Panel Plan

A Plan that provides medical or dental benefits primarily in the form of services through a panel of employed or contracted providers, and that limits or excludes benefits provided by providers outside of the panel, except in the case of emergency or if referred by a provider within the panel.

Primary Plan

The Plan that determines and provides or pays benefits without taking into consideration the existence of any other Plan.

Secondary Plan

A Plan that determines, and may reduce its benefits after taking into consideration, the benefits provided or paid by the Primary Plan. A Secondary Plan may also recover from the Primary Plan the Reasonable Cash Value of any services it provided to you.

GM6000 COB11

Allowable Expense

A necessary, reasonable and customary service or expense, including deductibles, coinsurance, that is covered in full or in part by any Plan covering you. When a Plan provides benefits in the form of services, the Reasonable Cash Value of each service is the Allowable Expense and is a paid benefit.

Examples of expenses or services that are not Allowable Expenses include, but are not limited to the following:

(1) An expense or service or a portion of an expense or service that is not covered by any of the Plans is not an Allowable Expense.

(2) If you are confined to a private Hospital room and no Plan provides coverage for more than a semiprivate room, the difference in cost between a private and semiprivate room is not an Allowable Expense.

(3) If you are covered by two or more Plans that provide services or supplies on the basis of reasonable and customary fees, any amount in excess of the highest reasonable and customary fee is not an Allowable Expense.

(4) If you are covered by one Plan that provides services or supplies on the basis of reasonable and customary fees and one Plan that provides services and supplies on the basis of negotiated fees, the Primary Plan's fee arrangement shall be the Allowable Expense.

(5) If your benefits are reduced under the Primary Plan (through the imposition of a higher coinsurance percentage, a deductible and/or a penalty) because you did not comply with Plan provisions or because you did not use a preferred provider, the amount of the reduction is not an Allowable Expense. Such Plan provisions include second surgical opinions and precertification of admissions or services.

Claim Determination Period

A calendar year, but does not include any part of a year during which you are not covered under this policy or any date before this section or any similar provision takes effect.

GM6000 COB12

Reasonable Cash Value

An amount which a duly licensed provider of health care services usually charges patients and which is within the range of fees usually charged for the same service by other health care providers located within the immediate geographic area where the health care service is rendered under similar or comparable circumstances.

Order of Benefit Determination Rules

A Plan that does not have a coordination of benefits rule consistent with this section shall always be the Primary Plan. If the Plan does have a coordination of benefits rule consistent with this section, the first of the following rules that applies to the situation is the one to use:

(1) The Plan that covers you as an enrollee or an employee shall be the Primary Plan and the Plan that covers you as a Dependent shall be the Secondary Plan;

(2) If you are a Dependent child whose parents are not divorced or legally separated, the Primary Plan shall be the Plan which covers the parent whose birthday falls first in the calendar year as an enrollee or employee;

(3) If you are the Dependent of divorced or separated parents, benefits for the Dependent shall be determined in the following order:

- first, if a court decree states that one parent is responsible for the child's healthcare expenses or health coverage and the Plan for that parent has actual knowledge of the terms of the order, but only from the time of actual knowledge;
- then, the Plan of the parent with custody of the child;
- then, the Plan of the spouse of the parent with custody of the child;
- then, the Plan of the parent not having custody of the child, and

- finally, the Plan of the spouse of the parent not having custody of the child.

GM6000 COB13

(4) The Plan that covers you as an active employee (or as that employee's Dependent) shall be the Primary Plan and the Plan that covers you as laid-off or retired employee (or as that employee's Dependent) shall be the secondary Plan. If the other Plan does not have a similar provision and, as a result, the Plans cannot agree on the order of benefit determination, this paragraph shall not apply.

(5) The Plan that covers you under a right of continuation which is provided by federal or state law shall be the Secondary Plan and the Plan that covers you as an active employee or retiree (or as that employee's Dependent) shall be the Primary Plan. If the other Plan does not have a similar provision and, as a result, the Plans cannot agree on the order of benefit determination, this paragraph shall not apply.

(6) If one of the Plans that covers you is issued out of the state whose laws govern this Policy, and determines the order of benefits based upon the gender of a parent, and as a result, the Plans do not agree on the order of benefit determination, the Plan with the gender rules shall determine the order of benefits.

If none of the above rules determines the order of benefits, the Plan that has covered you for the longer period of time shall be primary.

When coordinating benefits with Medicare, this Plan will be the Secondary Plan and determine benefits after Medicare, where permitted by the Social Security Act of 1965, as amended. However, when more than one Plan is secondary to Medicare, the benefit determination rules identified above, will be used to determine how benefits will be coordinated. This plan does not coordinate benefits with the Medicare Advantage Option.

Effect on the Benefits of This Plan

If this Plan is the Secondary Plan, this Plan may reduce benefits so that the total benefits paid by all Plans during a Claim Determination Period are not more than 100% of the total of all Allowable Expenses.

GM6000 COB14M

Recovery of Excess Benefits

If CIGNA pays charges for benefits that should have been paid by the Primary Plan, or if CIGNA pays charges in excess of those for which we are obligated to provide under the Policy, CIGNA will have the right to recover the actual payment made or the Reasonable Cash Value of any services.

CIGNA will have sole discretion to seek such recovery from any person to, or for whom, or with respect to whom, such services were provided or such payments made by any insurance company, healthcare plan or other organization. If we request, you must execute and deliver to us such instruments and documents as we determine are necessary to secure the right of recovery.

Right to Receive and Release Information

CIGNA, without consent or notice to you, may obtain information from and release information to any other Plan with respect to you in order to coordinate your benefits pursuant to this section. You must provide us with any information we request in order to coordinate your benefits pursuant to this section. This request may occur in connection with a submitted claim; if so, you will be advised that the "other coverage" information, (including an Explanation of Benefits paid under the Primary Plan) is required before the claim will be processed for payment. If no response is received within 90 days of the request, the claim will be denied. If the requested information is subsequently received, the claim will be processed.

GM6000 COB15

Subrogation and Reimbursement

Subrogation is the substitution of one person or entity in the place of another with reference to a lawful claim, demand or right. If you receive a benefit payment from the Plan for an Injury caused by a third party, and you later receive any payment for that same condition or Injury from another person, organization or insurance company, we have the right to recover any payments made by the Plan to you. This process of recovering earlier payments is called subrogation. In case of subrogation, you may be asked to sign and deliver information or documents necessary for us to protect our right to recover benefit payments made. You agree to provide us all assistance necessary as a condition of participation in the Plan, including cooperation and information submitted as supplied by a workers' compensation, liability insurance carrier, and any medical benefits, no-fault insurance, or school insurance coverage that are paid or payable.

We shall be subrogated to and shall succeed to all rights of recovery, under any legal theory of any type, for the reasonable value of services and benefits we provided to you from any or all of the following:

Third parties, including any person alleged to have caused you to suffer injuries or damages.

- Your employer.
- Any person or entity obligated to provide benefits or payments to you.

You agree as follows:

- To cooperate with us in protecting our legal rights to subrogation and reimbursement.
- That we may, at our option, take necessary and appropriate action to preserve our rights under these subrogation provisions.
- To execute and deliver such documents including consent to release medical records, and provide such help (including responding to requests for information about any accident or injuries and making court appearances) as we may reasonably request from you.
- You will do nothing to prejudice our rights under this provision, either before or after the need for services or benefits under the Plan.

Refund of Overpayments

If we pay benefits for expenses incurred on account of a Covered Person, that Covered Person, or any other person or organization that was paid, must make a refund to us if either of the following apply:

- All or some of the expenses were not paid by the Covered Person or did not legally have to be paid by the Covered Person.
- All or some of the payment we made exceeded the benefits under the Plan.

The refund equals the amount we paid in excess of the amount we should have paid under the Plan. If the refund is due from another person or organization, the Covered Person agrees to help us get the refund when requested.

If the Covered Person, or any other person or organization that was paid, does not promptly refund the full amount, we may reduce the amount of any future benefits that are payable under the Plan. The reductions will equal the amount of the required refund. We may have other rights in addition to the right to reduce future benefits.

Payment of Benefits

To Whom Payable

All Medical benefits are payable to you. However, at the option of CIGNA, all or any part of them may be paid directly to the person or institution on whose charge claim is based.

Medical benefits are not assignable unless agreed to by CIGNA. CIGNA may, at its option, make payment to you for the cost of any Covered Expenses received by you or your Dependent from a Non-Participating Provider even if benefits have been assigned. When benefits are paid to you or your Dependent, you or your Dependent is responsible for reimbursing the Provider. If any person to whom benefits are payable is a minor or, in the opinion of CIGNA, is not able to give a valid receipt for any payment due him, such payment will be made to his legal guardian. If no request for payment has been made by his legal guardian, CIGNA may, at its option, make payment to the person or institution appearing to have assumed his custody and support.

If you die while any of these benefits remain unpaid, CIGNA may choose to make direct payment to any of your following living relatives: spouse, mother, father, child or children, brothers or sisters; or to the executors or administrators of your estate.

Payment as described above will release CIGNA from all liability to the extent of any payment made.

Time of Payment

Benefits will be paid by CIGNA when it receives due proof of loss. All claims must be filed within twenty-four (24) months of the date of service.

Recovery of Overpayment

When an overpayment has been made by CIGNA, CIGNA will have the right at any time to: (a) recover that overpayment from the person to whom or on whose behalf it was made; or (b) offset the amount of that overpayment from a future claim payment.

Calculation of Covered Expenses

CIGNA, in its discretion, will calculate Covered Expenses following evaluation and validation of all provider billings in accordance with:

- the methodologies in the most recent edition of the Current Procedural terminology.
- the methodologies as reported by generally recognized professionals or publications.

GM6000 TRM366

Termination of Insurance

General Information about When Coverage Ends

The Board of Community Health may discontinue the SHBP and/or all benefit options at any time.

Certain employers may choose to stop offering SHBP coverage to employees or take actions that cause a termination of coverage for their employees:

Local school systems may withdraw from the plan for public school employees other than teachers. That means they can stop offering SHBP coverage to employees who are eligible for the plan for other public school employees and are not eligible for the plan for teachers. See the Eligibility section for more information.

State authorities participating in the ERS may stop offering SHBP coverage to employees and retirees,

Charter schools that elected to offer SHBP coverage to employees may revoke that election through action or inaction (such as failure to pay required contributions) and thereby stop offering SHBP coverage to employees,

Employers that offer SHBP coverage to employees through a contract with DCH may stop offering SHBP coverage through action or inaction that causes the contract to terminate, and

Local school boards may stop offering SHBP coverage to school board members.

When coverage ends because the Board of Community Health discontinues the SHBP or because your employer stops offering the SHBP, this termination of coverage does not create continuation rights. However, you may have rights to continue coverage if you resign or retire while your employer still offers the Plan.

Whenever coverage ends for any reason, your entitlement to benefits automatically ends on the date that coverage ends, even if you are hospitalized or are otherwise receiving medical treatment on that date.

When your coverage ends, we will still pay claims for Covered Health Services that you received before your coverage ended. However, once your coverage ends, we do not provide benefits for health services that you receive for medical conditions that occurred after your coverage ended, even if the underlying medical condition occurred before your coverage ended.

An Enrolled Dependent's coverage ends on the date the Member's coverage ends.

When Coverage Ends For You

Your coverage generally will end if:

- you no longer qualify under any category listed under the eligibility rules and your payroll deductions for coverage have ceased;
- you do not make direct-pay premium payments on time;
- you do not submit required premiums to your employer while you are on an unpaid leave of absence;
- you resign or otherwise end your employment;
- you are laid off because of a formal plan to reduce staff;
- your hours are reduced so that you are no longer benefits eligible;
- you do not return to active work after an approved unpaid leave of absence;
- you are terminated by your employer;
- you intentionally misrepresent eligibility for SHBP coverage for yourself or any covered dependents;
- you intentionally misrepresent eligibility for waiver of the tobacco or spousal surcharge, either by failing to answer the questions truthfully or failing to notify DCH, SHBP Division of a change to your answers

during the year;

- Member contributions not remitted to the Plan by the due date may result in suspension/and or termination of coverage; or
- your employer stops offering the SHBP, either by action (such as withdrawing from the plan for public school employees other than teachers) or inaction (such as not paying required contributions).

Coverage for Member ends at the end of the month following the month in which the last premium is deducted from your earned paycheck or at the end of paid coverage. Premiums will not be deducted from final leave pay.

Note: If an Employing Entity fails to remit Premiums or documentation or fails to reconcile bills in the manner required by the Plan, the Plan may suspend coverage for all Enrolled Members of the Employing Entity. During a period of suspended coverage, benefits will continue to be paid, but the Employing Entity will be directly responsible for reimbursing SHBP for all claims paid. If the Employing Entity fails to provide the required Premiums or documentation or reconcile bills, coverage may be terminated for all Enrolled Members of the Employing Entity. In this instance, DCH, SHBP Division will send a notice to Enrolled Members before the coverage is terminated. Although termination of coverage in this situation does not give rise to COBRA continuation rights, members who have a right to continue coverage after resignation or retirement under State law will be provided an opportunity to do so if they stop working for the Employing Entity while SHBP coverage is in place.

- Coverage will end beginning on the date that your false response is discovered and new coverage will not be available for at least 12 months thereafter.

When Coverage May Be Continued For You

SHBP allows individuals to continue their SHBP coverage in certain situations when it would have otherwise ended.

If you have this situation…	You will be affected in this way:
Leave your job: Have less than eight years of service	You may continue coverage for up to 18 months under COBRA provisions.
Leave your job and: • Have at least eight years of service	You may continue coverage by: • Completing and submitting the Direct Pay Enrollment Change form within 60 days of when coverage would end; • Pay the full cost of coverage* until you start receiving an annuity under the retirement system (if applicable); • Provide a statement from retirement system verifying your service; and • Pay annuitant premium once annuity begins if you have notified DCH, SHBP Division to start your deductions from your annuity • *Except for participants covered under the Legislative Retirement System
The chart above applies for most SHBP Members; certain parts of the Georgia code may stipulate other conditions for SHBP continuation.	

Member contributions not remitted to the Plan by the due date may result in suspension and/or termination of coverage.

When Coverage May Be Continued For Your Dependents

Coverage for your dependents will end at the same time you lose coverage because you are no longer eligible. Here are other situations that can affect coverage for you and your dependents.

For Your Dependents	Effect on coverage
If enrolled dependent is under age 26	• Coverage for your dependents will end at the same time you lose coverage because you are no longer eligible. • Coverage will end for children at age 26 unless disabled prior to age 26 and the appropriate documentation has been submitted and approved by DCH, SHBP Division.
If you divorce, your spouse loses coverage as your dependent*	Coverage ends at the end of the month in which the divorce becomes final.**
If you or your spouse or eligible dependent(s) lose(s) other group health insurance coverage because of change in employment	Before you lose coverage or within 31 days after losing coverage, file request for SHBP coverage, which will start on the first day of the month following the request.
If you declined coverage for yourself or your dependents because of other group health insurance coverage, and you later lose that coverage	You may enroll yourself and dependents if you request this coverage within 31 days of the qualifying event. Coverage will be effective on the first day of the month following the request.

*A divorced spouse may continue Plan coverage by electing COBRA continuation coverage, which is limited to 36 months of coverage. The spouse must request a COBRA information packet from the DCH, SHBP Division within 60 days of the qualifying event.

** The Plan must be notified at the time the divorce is final and not as a discontinuation of coverage for the spouse or other dependent during Open Enrollment.

****Discontinuation of coverage for a spouse or other covered dependent(s) during Open Enrollment does not qualify as a COBRA event. In order for a spouse or other dependent(s) to be eligible for continuation of coverage under COBRA, the DCH, SHBP Division must be notified at the time the divorce is final. If a spouse's coverage is discontinued during Open Enrollment in anticipation of divorce, the former spouse may be able to elect COBRA coverage when the divorce is final.**

Open Enrollment and Retiree Option Change Period

During Open Enrollment and the Retiree Option Change Period, Members must answer surcharge questions and make their coverage choices for the upcoming Plan Year. If you do not take any action during Open Enrollment or the Retiree Option Change Period, you will be required to pay surcharges. See the Surcharge section of this SPD for more information. See the current *Health Plan Decision Guides* for Web addresses and instructions. If you do not have Internet access or if your request is in the middle of a Plan year, then:

- An active Employee should notify his/her personnel/payroll office to obtain the appropriate form to complete and submit. If you miss the deadline, you won't be able to make your change until the next Open Enrollment or Retiree Option Change Period unless a qualifying event occurs.
- A former employee should contact the SHBP Call Center directly at 800-610-1863. You must complete and return the form by the appropriate deadline. Changes permitted for former employees are limited, please refer to the retiree section for more details.

Provisions for Eligible Annuitants, Eligible Former Employees & Those Considering Retirement or Resignation after 8 Years of Service

Note: This Section does not apply to individuals who have less than eight years of service with a state retirement system or who are eligible because they work for an entity that has joined the SHBP through a contract with DCH. The terms of the contract control. This SPD does not contain specific information about how much former employees and annuitants are required to pay for continuation coverage. Premium rates are set by the Board of Community Health, usually on an annual basis. Premium rates for former employees who are not annuitants usually reflect the entire cost of coverage plus an administrative fee. Premium rates for annuitants currently reflect a subsidy for certain options. The Board of Community Health is authorized to set premiums by resolution, and may change premium requirements at any time with advanced notice. The Board approved a change in the methodology for subsidizing premiums for annuitants and their dependents. The new methodology adjusts the subsidy for annuitant premiums based on Years of Service for future annuitants who had less than five Years of Service as of January 1, 2012. This change will impact employees who had less than five years of service as of January 1, 2012 when they retire with an annuity in the future. Information will be made available before annuitant premiums based on Years of Service apply to any annuitant. Current rates for active employees, former employees, annuitants are posted on the DCH website at www.dch.georgia.gov.

Plan Membership

This section includes Plan Membership, Plan options and Medicare information for enrolled annuitants and enrolled former employees as well as important points to consider if you are considering retiring with an annuity or resigning with eight or more years of service. All former employees and annuitants age 65 or older who choose to enroll in an SHPB option that is not a Medicare Advantage (MA) option will pay the full cost of SHBP coverage. See the *Retiree Decision Guide* for more information. SHBP defines an annuitant as an individual who has started drawing a monthly check from a State Retirement System. If your monthly annuity check is not large enough to pay the full premium, you may arrange with DCH, SHBP Division to make direct payments of the annuitant premium.

Disabled individuals under the age of 65 with Medicare Parts A and B have two additional Medicare Advantage options. Contact SHBP if you have been approved by Social Security for Medicare due to disability and are under the age of 65 to discuss your options and rates. If you will be drawing an annuity you can be covered under any SHBP plan and will pay the Annuitant premium.

This Section is broken down by the various scenarios under which benefits may be continued.

Eligibility

8+ Years of Service with a State Retirement System (but not eligible to draw an annuity in the future) – Direct Pay

- You may continue your health insurance after active employment ends by paying the State Extended Coverage premiums directly to DCH, SHBP Division
- Your Plan options are the same as active employees unless you are age 65 and have Medicare Part B and you will then have two additional Medicare Advantage Options
- You must complete the Direct Pay Enrollment Form and remit monthly State Extended Coverage premiums to DCH, SHBP Division

8+ Years of Service (and able to draw an annuity in the future) – Direct Pay

- You may continue your health insurance after active employment ends by paying the required State Extended Coverage premiums directly to DCH, SHBP Division

- Your Plan options are the same as active employees unless you are age 65 and have Medicare Part B and you will then have two additional Medicare Advantage Options
- You must complete the Direct Pay Enrollment Form and remit monthly State Extended Coverage premiums to SHBP until you start drawing an annuity
- You must continue paying the State Extended Coverage premiums directly to DCH, SHBP Division every month until you begin drawing an annuity and are able to pay the Annuitant premiums
- When you start drawing your annuity, you will need to notify DCH, SHBP Division in order to have the premium changed from the State Extended Coverage premium to the Annuitant premium and to set up deductions from your annuity check
- You will need to confirm that the correct deduction comes out of your first annuity check
- If your annuity check is too small for the Annuitant premiums to be deducted, then you will pay the Annuitant premiums directly to DCH, SHBP Division
- You may decrease your tier at any time

Eligibility as an Annuitant

You may be able to continue Plan coverage if you are enrolled in the Plan when you retire and are immediately eligible to draw a retirement annuity from any of these State Retirement Systems:

- Employees' Retirement System (ERS)
- Teachers Retirement System (TRS)
- Public School Employees Retirement System (PSERS)
- Local School System Teachers Retirement Systems
- Fulton County Retirement System (eligible Members)
- Legislative Retirement System
- Superior Court Judges or District Attorney's Retirement System

Important Note: Individuals who withdraw all money from their respective retirement system will not be able to continue health coverage as an annuitant. Eligibility for temporary extended coverage under COBRA provisions would apply, and individuals with eight or more years of service are eligible for ongoing continued coverage as described below.

Options and Rates when Eligible to Immediately Draw an Annuity

Under Age 65

- Plan options are currently the same as for active employees
- Rates are the currently the same as for active employees
- If in ERS, TRS or PSERS Retirement Systems your coverage will automatically roll over into retirement
- If in another state retirement system, you will need to complete a Retiree/Surviving Spouse Form

Age 65+ and have Medicare Part B

- Premiums and options change at age 65.
- Plan options are currently the same as for active employees + two additional Medicare Advantage options
- If you enroll in Medicare Part B at age 65, you may enroll in one of the SHBP Standard or Premium Medicare Advantage Options (currently subsidized) OR
- You may have one of the other SHBP options but you will pay the full cost (not subsidized)
- MA options include Medicare Parts A, B and D

- The benefits paid under the MA options reflect what Medicare would have paid (except for some plan enhancements); therefore, it does not coordinate benefits with any Medicare
- If you are enrolled in a SHBP MA Option and enroll in an individual MA or Part D Plan, you may lose eligibility for SHBP coverage
- If in ERS, TRS or PSERS Retirement Systems your coverage will automatically roll over into retirement
- If in another state retirement system, you will need to complete a Retiree/Surviving Spouse Form

Split Eligibility – one person under age 65 and one person 65 or older with Medicare Part B

- Plan options are currently the same as for active employees, and, in addition, Medicare Advantage options are available to the person who purchases and maintains Medicare Part B
- If the person with Medicare Part B maintains Medicare Part B and enrolls in a Medicare Advantage option, coverage is currently subsidized, and an annuitant's dependent who is not eligible for Medicare Part B may enroll in any non-MA option on a subsidized basis.
- If any person age 65 or older enrolls in a non-MA option, the full cost of all coverage elected must be paid – there is no subsidized coverage.
- If receiving your first check from ERS, TRS or PSERS Retirement Systems, your coverage will automatically roll over into retirement
- If DCH, SHBP Division has received and processed your Medicare Part B information, we will roll your coverage to the MA Standard under your current healthcare vendor.
- If you have dependents not eligible for the MA option, their coverage will roll to the option they had at the time you became covered by the MA option

SHBP will continue to pay primary benefits for former employees not enrolled in a Medicare Advantage Option at age 65 or older. See the Medicare COB section as there is important information you need to know.

IMPORTANT NOTICE: The HDHP option is not a creditable plan for your Medicare prescription drug coverage. If you do not enroll in a Medicare Part D Plan, even if actively working, or in a Medicare Advantage Plan when you first become eligible, you will pay a late enrollment penalty of at least 1 percent (up to a maximum of 19 percent) for the period you did not have creditable coverage. This penalty will apply each month whether you are in the Medicare Advantage Plan or an individual Part D Plan. SHBP Medicare Advantage Plans include Part D prescription drug coverage.

NOTE: Individuals who have lived at least 5 years in the United States may purchase Medicare Part B coverage even if they did not contribute to Social Security or work the number of required quarters. Enrollment in Medicare Part B is required to enroll in a Medicare Advantage Option

Applying for Coverage Continuation as an Annuitant

You must apply for continued coverage for yourself and Covered Dependents within 60 days of the date your coverage as an active employee ends. Application can be made on a Retiree/ Surviving Spouse Form, available online at www.dch.georgia.gov/shbp under forms or by contacting the Plan's Eligibility Section at (800) 610-1863. **Failure to apply on time or failure to make the correct premium payments will permanently end your SHBP coverage.** Members receiving their first monthly annuity check from ERS, TRS, and PSERS will be automatically enrolled in the same option they had as an active employee, unless

Medicare Part B coverage has been reported to SHBP. Retirees with Medicare Part B coverage on file will automatically be enrolled in the Medicare Advantage Standard Option offered by the claims administrator they currently have. Currently, only the Medicare Advantage options are subsidized for annuitants over age 65 or who are eligible for Medicare Part B due to disability. The Board of Community Health establishes required premiums by resolution, and premiums may be changed at any time with advance notice.

Annuitants may request to change Plan options if the request is made within 31 days of retirement. You may request the change by downloading, printing and completing the Retiree/Surviving Spouse Form available online at www.dch.georgia.gov/shbp or you may call the SHBP Call Center at (800) 610-1863 to request a form. Currently, Plan options include the Medicare Advantage Premium Plan, Wellness and Standard High Deductible Health Plan (HDHP), Wellness and Standard Health Maintenance Organization (HMO), and Wellness and Standard Health Reimbursement Account (HRA) offered through SHBP. Annuitants who are eligible for TRICARE may also purchase a TRICARE Supplement (not subsidized or sponsored by DCH or any employer) as an alternative to SHBP options. If you or your covered dependent is age 65 and elects to enroll in one of the non-MA options, you will pay the full cost of your coverage; there is no subsidy. The TRICARE Supplement may not be purchased by individuals with Medicare.

When Annuitant Coverage Begins

If you are eligible for a monthly annuity at the time you retire, your coverage as an annuitant starts immediately at retirement, provided that you have all required annuitant premiums deducted from your monthly annuity check or, if the check is not large enough, pay all required annuitant premiums directly to DCH, SHBP Division. NOTE: You must have continuous SHBP coverage from active employee status to annuitant status. If for some reason, there is a delay in your annuity being setup resulting in a gap of coverage, you must remit required annuitant premiums for this period in order to have health insurance as an annuitant. Once set up as an annuitant, payment must be made each month for your health insurance either through deductions from your annuity check or by sending the payment directly to DCH, SHBP Division (only allowed if the annuity check is too small). If required payments are not received on time, your coverage will be terminated with no right to reinstatement of coverage. Coverage for your dependents (if you elect to continue dependent coverage) starts on the same day that your coverage as an annuitant begins. A change from You to You + Spouse, You + Child(ren) or You + Family as a former employee is allowed only when you have a qualifying event and make the request within 31 days of the event. (90 days to add a newborn).

Note: If you discontinue coverage at the time you retire or at a later date, you will not be able to get this coverage back unless you return to work in a position that offers SHBP coverage.

When Coverage as a Former Employee (non-Annuitant) Begins

If you elect to continue coverage as a former employee with 8 or more Years of Service, your coverage as a former employee starts immediately upon resignation, provided that you make all required State Extended Coverage premium payments on time and submit required documentation to the DCH, SHBP Division on time. If required payments are not received on time, your coverage will be terminated with no right to reinstatement of coverage. Coverage for your dependents (if you elect to continue dependent coverage) starts on the same day that your coverage as a former employee begins. A change from You to You + Spouse, You + Child(ren) or You + Family as a former employee is allowed only when you have a qualifying event and make the request within 31 days of the event. (90 days to add a newborn).

Note: If you discontinue coverage at the time you resign with 8 or more Years of Service or at a later date, you will not be able to get this coverage back unless you return to work in a position that offers SHBP coverage.

When Will Coverage as an Annuitant or Former Employee End

For You

- My coverage will end if I choose to cancel my coverage
- My coverage will end if I am paying SHBP directly for my premiums and I stop paying
- My coverage will end if I intentionally misrepresent my eligibility or the eligibility of my dependents, or if I intentionally misrepresent my eligibility for waiver of a spousal surcharge or a tobacco surcharge in my responses to the surcharge questions or failing to notify DCH, SHBP Division of a change to my responses that would make me ineligible for the waiver.
- My coverage may end if my former employer stops offering SHBP coverage.

For Your Dependents

Coverage for your dependents will end when:

- They are no longer eligible
- A Social Security Number is not provided by the deadline
- You change from You + Family to You coverage
- Your coverage ends
- When they are approved for coverage under PeachCare for Kids

Keep in mind that if dependents are dropped from your coverage, you will not be able to enroll them again – unless you have a qualifying event. Loss of PeachCare or TRICARE Supplement coverage is a qualifying event to add your dependent(s). The request resulting from loss of TRICARE Supplement must be made within 31 day of loss of coverage and 60 days within loss of Peachcare for Kids coverage.

If your Medicare Advantage coverage is terminated by CMS due to enrollment in another plan or failure to pay Medicare Part B premiums, the DCH, SHBP Division will enroll you in the option (Standard HMO, HDHP, HRA or Wellness HMO, HDHP, HRA) you had before if the State Extended Coverage premium is received. If your option is not offered, you will be defaulted to the standard level of the option you previously had **before you enrolled in the MA PPO Plan. You will pay the total cost of coverage and will not receive any subsidy.**

Continuing Dependent Coverage at Your Death (for Annuitants)

In the event of your death, your covered surviving spouse or eligible dependents should contact the applicable State Retirement System (ERS, TRS, PSERS, etc.) and the DCH, SHBP Division as soon as possible. To continue coverage, surviving spouses or eligible children must complete a Retiree/Surviving Spouse Form and send it to the DCH, SHBP Division within 90 days of your death. Continuation coverage as a surviving dependent is an alternative to COBRA coverage.

Plan provisions vary for survivors:

If surviving spouse receives an immediate annuity from a State Retirement System

- Plan coverage may continue for the surviving spouse and any covered dependent children after your death
- Surviving spouse premiums (set by the Board of Community Health, and currently subsidized) will be deducted from the annuity
- Surviving spouse must send premium payments directly to DCH, SHBP Division if the annuity is not large enough to cover premium
- Surviving spouse's new dependents or new spouse *cannot* be added to survivor's coverage

- Surviving spouse who becomes eligible for SHBP coverage as an active employee must discontinue the surviving spouse coverage and enroll as an active employee.
- When a surviving spouse ends active employee status and returns to a surviving spouse status, the surviving spouse coverage may be reinstated after notifying DCH, SHBP Division within 31 days. The surviving spouse will be eligible to continue coverage, based on the conditions that first made him or her eligible as a surviving spouse.

If surviving child receives an immediate annuity from a State Retirement System

- Plan coverage may continue after your death
- Surviving child's premium (set by the Board of Community Health, and currently subsidized) will be deducted from the annuity
- Surviving child must send premium payments directly to DCH, SHBP Division if the annuity is not large enough to cover premium
- Surviving child's coverage will terminate when he or she no longer satisfies the definition of a dependent child
- Surviving child may not add dependents to the coverage
- Surviving child who becomes eligible for SHBP coverage as an active employee must discontinue the surviving child coverage and enroll as an active employee.
- When a surviving child ends active employee status and returns to a surviving child status, the surviving spouse child coverage may be reinstated after notifying DCH, SHBP Division within 31 days. The surviving child will be eligible to continue coverage, based on the conditions that first made him or her eligible as a surviving child.

Surviving spouse does not receive an immediate annuity from a State Retirement System

- Plan coverage may continue after your death if surviving spouse was married to you at least one year before your death
- Surviving spouse must send surviving spouse premiums (set by the Board of Community Health, and currently subsidized) directly to the DCH, SHBP Division
- Coverage ends if the surviving spouse remarries

Surviving child does not receive annuity and there is no surviving spouse.

- Plan coverage may continue under COBRA provisions.

Making Changes to Your Retiree Coverage (for all Former Employees and Annuitants)

You can make changes to your coverage tier only at these times:

- Within 31 days of a qualifying event
  - You may add a dependent as long as the change is consistent with the qualifying event
  - You have 90 days to add a newborn
- During the annual Retiree Option Change Period.
  - You may change your Plan option only
  - Re-renrollment of yourself or your dependents is only permitted as described below

- Adding dependents is not permitted during this Retiree Option Change Period (ROCP) unless you have a qualifying event as described in the section below during the Retiree Option Change.

Discontinuing Your Retiree Coverage or Discontinuing Your Dependent Coverage (for all Former Employees and Annuitants)

You can discontinue coverage at any time. If you discontinue coverage you may never re-enroll in the SHBP as a former employee or annuitant unless you discontinued SHBP coverage due to enrollment in TRICARE Supplemental coverage and maintained continuous coverage under TRICARE Supplemental coverage until re-enrollment in SHBP coverage during a Retiree Option Change Period.

You may discontinue coverage for your dependents at any time. However, you may never re-enroll dependents in SHBP coverage unless you discontinued the dependent child's SHBP coverage due to enrollment of your dependent child in PeachCare for Kids and the dependent child has maintained continuous coverage under SHBP or PeachCare for Kids until re-enrollment in SHBP coverage during a Retiree Option Change Period.

Except as described above, if you discontinue SHBP coverage for yourself or your dependents, you will not be able to get the coverage back unless you return to work in a position that offers SHBP coverage.

Qualifying Events for all Former Employees and Annuitants

Examples of a qualifying event are getting married, having a baby or spouse loses eligibility for health insurance. If you experience a qualifying event, you must request a coverage change within 31 days of the qualifying event (90 days for a newborn) by:

- Contacting the DCH, SHBP Division directly.
- Returning the necessary form(s) with any requested documentation and the dependent's Social Security Number (SSN) to the Plan by the deadline.
- * Fill out the form(s) completely. The Centers of Medicare & Medicaid Services (CMS) require DCH, SHBP Division to capture the SSN for all dependents. SHBP will provide coverage for a dependent to age two without a SSN.

If you miss the deadline, you will not have another change to make the desired change. If the deadline is met, your change will take effect on the first day of the month following the receipt of your request, unless indicated in the chart below.

***Do not hold form requesting change even if you are waiting on documentation. Request must be made within 31 days of qualifying event.**

If you have this qualifying event…	You may…
You retire and immediately qualify for a retirement annuity from a State Retirement System You must complete and submit the Retiree Surviving Spouse form no later than 60 days after leaving active employment unless you are in one of the retirement systems listed below. Your coverage will automatically roll from active to annuitant status if in ERS, TRS or PSERS. Coverage must be continuous from active to annuitant status.	• Lower coverage tier to You, You + Spouse, or You + Child(ren). • Change to any available plan option. • Discontinue coverage.
If your State Retirement System check no longer covers the premium for your health coverage You will be changed to a direct pay status and the premium will include an administrative fee. You will pay DCH, SHBP Division monthly for your health coverage.	• Lower coverage tier to You, You + Spouse, or You + Child(ren). • Change to any available plan option. • Discontinue coverage.

If you have this qualifying event…	You may…
If you are working in a benefits eligible position and are continuing to receive your annuity from a State Retirement System You must advise DCH, SHBP Division when you terminate your benefits eligible position or you will not have health coverage as an annuitant. You will need to complete the Retiree/Surviving Spouse form to have your health insurance deductions taken out of your retirement check.	• You must have coverage as an active employee • You must follow the active coverage rules as long as you are working in a SHBP benefits eligible position **Note**: Once you terminate your SHBP benefits eligible position you must follow the plan rules for annuitants
You, your spouse, or enrolled dependents turn age 65 • You must submit a copy of the Medicare Part B enrollment of the person who turned 65. Failure to submit a copy of your Medicare Part B enrollment will result in an increase in premiums to the full cost of coverage. • A copy of the Medicare card(s) or proof of Medicare coverage should be submitted the first of the month prior to the month you or your dependent reach age 65. Enrollment in Medicare Part B is necessary to enroll in a Medicare Advantage option. Part B premiums must be paid in order to keep Medicare Advantage coverage. • Unless a request is made to enroll in the Medicare Advantage Premium Plan, the person who turns 65 will be rolled into the Medicare Advantage Standard Plan with CIGNA (currently subsidized for annuitants) if DCH, SHBP Division has received and processed a copy of the Medicare Part B enrollment. **Note:** The HDHP is not a creditable plan for your Medicare prescription drug coverage. If you do not enroll in a Medicare Part D Plan, even if actively working or a Medicare Advantage Plan when you first become eligible, you will pay a late enrollment penalty of at least 1 percent (up to a maximum of 19 percent) for the period you did not have creditable coverage. This penalty will apply each month whether you are in the Medicare Advantage Plan or an individual Part D Plan. SHBP Medicare Advantage Plans include Part D prescription drug coverage.	• The person who turns 65 may change from the Medicare Advantage Standard Plan to the Medicare Advantage Premium Plan • The person who turns 65 may change from the Medicare Advantage Standard Plan to any non-MA Plan option, and the full cost of coverage must be paid. **Note**: If your mailing address in SHBP records is a PO Box, CMS will not approve your enrollment into a MA Plan. You will remain in your current Plan option and must pay the full cost of coverage (without any subsidy) until you provide a Street Address and CMS approves your enrollment into a MA plan. **Note**: You will lose your SHBP MA coverage if you enroll in an individual Medicare Advantage or Part D plan or stop paying Medicare Part B premiums once enrolled in a SHBP MA option. DCH, SHBP Division will put you in the option (Standard HMO, HDHP, HRA or Wellness HMO, HDHP, HRA) you had before as long as the State Extended Coverage premium is received. If your option is not offered, you will be defaulted to the standard level of the option you previously had before you enrolled in the MA option and you will pay the total cost of coverage for that option.

If you have this qualifying event…	You may…
Acquire dependent because of marriage, birth, adoption or Qualified Medical Child Support Order (QMCSO) approved by DCH, SHBP Division Within 31 days of qualifying event (90 days for a newborn)	• Change coverage tier to add the dependent • Change your coverage option. • Add your eligible dependent(s).
• **Spouse's loss of eligibility for health insurance due to retirement.** Provide a letter from the other plan documenting loss of coverage and reason for loss of coverage is required. You will need to furnish the Social Security Number for each dependent you wish to cover. Note: Retirement without loss of eligibility for health insurance, discontinuation of coverage, reduction of benefits, or change in premiums ARE NOT qualifying events. Loss of eligibility for health insurance at retirement is a qualifying event.	• Change coverage tier to add the spouse. • Change coverage option. • Add your eligible spouse.
• **Spouse or enrolled dependent's employment status changes**, **affecting coverage eligibility under a qualified health plan** Provide a letter from the other plan documenting loss/gain of coverage for each covered individual, date and reason for loss is required. You will need to furnish the Social Security Number for each dependent you wish to cover.	• Change coverage tier. • Change coverage option. • Add your eligible dependent(s).
• **Loss of dependent(s) that impacts your Tier (i.e. loss of all eligible dependents – you may change tiers to you only coverage).** Must provide documentation stating the reason and date eligibility was lost unless the reason is because of reaching age 26.	• Change coverage tier.
• **Divorce.** You must provide copy of divorce decree and documentation of loss of other insurance coverage to add a dependent(s).	• Must remove ex-spouse from coverage. • Must remove stepchildren from coverage. • Change Coverage tier. • May change Plan option to any available plan option
You and spouse are both annuitants receiving annuity checks from State Retirement Systems and you each have annuity checks large enough to have annuitant premiums deducted	May change at any time from You + family coverage to each having You only coverage; a request to change to You only for you and your spouse must be filed at the same time.

Retiree Option Change Period

During the 30-day Retiree Option Change Period, generally from mid-October to mid-November each Plan year, you can make these changes to your coverage:

- Select a new coverage option;
- Change to a lower tier; or
- Discontinue coverage (**Note:** re-enrollments are not allowed).

Changes will take effect the following January 1st.

Before the Retiree Option Change Period begins, the Plan will send you a retiree information packet. The packet will include:

- Information on the Plan options;
- Steps for notifying the Plan about coverage selections for the new Plan year;
- Forms you may need to complete; and
- Informational resources.

To ensure that you receive the information packet, make sure the DCH, SHBP Division always has your most up-to-date mailing address. Mail letter notifying SHBP of new address to: SHBP, P.O. Box 1990, Atlanta, GA 30301-1990 or fax to our secure fax at 866-828-4796. Be sure to include the retiree's Social Security Number.

If You Return to Active Service

If you choose to return to active service with an employing entity under the Plan, whether immediately after you retire with an annuity or at a later date, your retirement annuity may be suspended or continued. SHBP coverage, however, must be purchased as an active employee with payroll deduction by your employer. You will need to complete enrollment paperwork with your employer and verify the deduction stopped with the retirement system.

When you return to retired status, retiree coverage will only be reinstated after notifying the DCH, SHBP Division within 31 days if you have continued to receive your retirement annuity. You will be eligible for continuous coverage, based on the conditions that first made you eligible as a retiree.

If you retired before the initial legislative funding for a particular employee group, you will not be entitled to annuitant coverage unless the final service period qualifies you for a monthly annuity from a State Retirement System.

Special Note: Re-enrollment into retiree coverage is not automatic if you continued to receive your retirement annuity check. You must request retiree coverage within 31 days of loss of active coverage or you will lose eligibility for retiree coverage.

Medicare Coordination of Benefits for all Former Employees and Annuitants for Health Reimbursement Account (HRA), High Deductible Health Plan (HDHP) and the Health Maintenance Organization (HMO) called Open Access Plus

If you enroll in a Medicare Advantage option after becoming eligible for Medicare, the Medicare Advantage plan will pay the Medicare approved benefits and any additional benefits SHBP has made to this Plan. Since this plan is a Medicare approved plan, this plan does not coordinate benefits with Medicare. If you are retired and are enrolled in a SHBP non Medicare Advantage option, SHBP will coordinate benefits with Medicare. Under Georgia law, the SHBP is required to subordinate health benefits to Medicare benefits (for non MA plans).

The chart below provides important details related to primary and secondary coverage based on your Medicare status **(for you and/or your dependents that are not enrolled in a Medicare Advantage plan):**

If you are retired and …	**The Plan will pay…**
…age 65, consider enrolling in Medicare Parts A, B and D two months prior to the month in which you turn 65 to maximize coverage	Secondary benefits starting on the first day of the month in which you turn 65
…age 65, Medicare eligible and do *not* enroll in Part A, Part B and Part D	Primary benefits; however, Plan premium will increase significantly
…age 65 or older and not entitled in Medicare (because have not lived in the U.S. for 5 years of longer)	Primary benefits; however, Plan premium will increase significantly.
. . age 65 or older and have dependents not entitled to Medicare because of age	Primary benefits for dependents.

The SHBP is not a supplemental plan to Medicare. The Plan will pay secondary benefits/coordinate benefits if retired and enrolled in Medicare and the Standard or Wellness HRA, Standard or Wellness HDHP, or Standard or Wellness HMO Option. The Plan does not pay secondary benefits with the Medicare Advantage Options.

All other Plan options pay benefits after Medicare pays benefits. That means that any Medicare coverage you or your dependents have will be the primary plan and the SHBP Plan option you have will be the secondary plan. To maximize coverage, you and your dependents should consider enrolling in Medicare Parts A, B and D two months before the month in which you turn 65.

Are you not yet eligible for Medicare?

- You may elect to have coverage under any of the non-Medicare plan options offered by SHBP.
- Annuitant health premiums are currently similar to those of active employees.
- Former employees with more than 8 Years of Service pay State Extended Coverage premiums

Are you eligible or about to be eligible for Medicare?

- Medicare is the country's health insurance program for people age 65 or older who qualify based on Medicare eligibility rules. Medicare also covers certain people with disabilities who are under age 65 and people of any age who have permanent kidney failure. Medicare becomes your primary insurance carrier once you are covered by Medicare. You are eligible for Medicare even if you never paid into Social Security. You and/or your spouse can purchase Medicare Part B if you are a U.S. Citizen, reside in the U.S., age 65 or older (or a legal non-citizen, age 65 or older, who resides and has lived in the U.S. for at least 5 years or longer).
- You will need to send a copy of your Medicare Card (A, B or D) to SHBP at P.O. Box 1990, Atlanta, GA 30301-1990 the first of the month prior to the month in which the retiree turns 65 or becomes eligible for Medicare because of disability. Options and premiums cannot be adjusted until copies of your Medicare cards are received and the change in premium is processed by the retirement system. Delay in submission of Medicare information will result in an increase in premiums to the full cost of the non-MA coverage, with no refund of the difference in premiums.

Due to Disability

- If you are disabled under Social Security, you may qualify for Medicare after a waiting period.

What if I have End Stage Renal Disease?

- If you or your dependents are enrolled in Medicare due to End Stage Renal Disease (ESRD), you may not enroll in a Medicare Advantage option during your first 30 months of Medicare coverage because SHBP is your primary coverage. After 30 months, when Medicare becomes primary, you may enroll in one of the Medicare Advantage plans. You will need to send the SHBP a copy of the letter advising of Medicare eligibility.

Medicare information is available at:

- www.cms.hhs.gov/medicarereform
- www.medicare.gov
- www.ssa.gov
- 1-800-669-8387 (Georgia Cares)
- 1-800-633-4227 (Medicare)
-

Legal Notices – Department of Community Health

State Health Benefit Plan Information Privacy Notice
Revised March 23, 2010

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. These reports 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, your employer may also get summary reports.

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 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 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 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 what they do.

Claims Administrators: Process all medical and drug claims; communicate with Members and their health care providers; and give extra help 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.

For Public Health Activities: The Plan may give PHI to government agencies that perform public health activities. For example, the Plan may give PHI to DCH employees in the Public Health Division who need it to do their jobs.

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 of 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/shbp. 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 800-610-1863

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

CIGNA Federal Other General Legal Requirements

Relationship with Providers

The relationships between SHBP, CIGNA, and Network providers are solely contractual relationships between independent contractors. Network providers are not our agents or employees, nor are they agents or employees of CIGNA. Neither CIGNA nor any of our employees are agents or employees of Network providers.

CIGNA does not provide health care services or supplies, nor does CIGNA practice medicine. Instead, CIGNA pays benefits for Covered Services. Network providers are independent practitioners who run their own offices and facilities. The credentialing process confirms public information about the providers' licenses and other credentials, but does not assure the quality of the services provided. Network providers are not the employees of SHBP or CIGNA, nor does either have any other relationship with Network providers such as principal-agent or joint venture. Neither we nor CIGNA are liable for any act or omission of any provider. CIGNA is not considered to be an employer of the SHBP for any purpose with respect to the administration or provision of benefits under this Plan.

Your employer is solely responsible for proper classification of your employment.

CIGNA is solely responsible for timely payment of Benefits.

The Plan Administrator, DCH, through the DCH, SHBP Division and your employer are jointly responsible for notifying you of the termination or modification of the Plan.

Your Relationship with Providers

The relationship between you and any provider is that of provider and patient.

- You are responsible for choosing your own provider.
- You must decide if any provider treating you is right for you. This includes Network providers you choose and providers to whom you have been referred.
- You must decide with your provider what care you should receive.
- Your provider is solely responsible for the quality of the services provided to you.

Incentives to You

Sometimes CIGNA may offer incentives to encourage you to participate in various wellness programs or certain disease management programs. The decision about whether or not to participate is yours alone but we recommend that you discuss participating in such programs with your Physician. These incentives are not benefits and do not alter or affect your benefits. Contact CIGNA if you have any questions.

Interpretation of Benefits

SHBP and CIGNA have sole and exclusive discretion to do all of the following:

- Interpret benefits provisions. SHBP has delegated to CIGNA the sole authority to interpret the HDHP Option as necessary to pay claims.
- Interpret the other terms, conditions, limitations and exclusions of the HDHP Option, including this SPD and any Riders and Amendments.
- Make factual determinations related to the HDHP Option and its benefits. SHBP and CIGNA may delegate this discretionary authority to other persons or entities that provide services in regard to the administration of the Plan.

Administrative Services

We may, in our sole discretion, arrange for various persons or entities to provide administrative services in regard to the Plan, such as claims processing. The identity of the service providers and the nature of the services they provide may be changed from time to time in our sole discretion. We are not required to give you prior notice of any such change, nor are we required to obtain your approval. You must cooperate with those persons or entities in the performance of their responsibilities.

Clerical Error

If a clerical error or other mistake occurs, that error does not create a right to benefits. These errors include, but are not limited to, providing misinformation on eligibility or benefit coverages or entitlements. It is your responsibility to confirm the accuracy of statements made by us or our designees, including CIGNA, in accordance with the terms of this SPD and other Plan documents.

Information and Records

At times we or CIGNA may need additional information from you. You agree to furnish us and/or CIGNA with all information and proofs that we may reasonably require regarding any matters pertaining to the Plan. If you do not provide this information when we request it, we may delay or deny payment of your benefits.

By accepting benefits under the Plan, you authorize and direct any person or institution that has provided services to you to furnish us or CIGNA with all information or copies of records relating to the services provided to you. We or CIGNA have the right to request this information at any reasonable time.

This applies to all Covered Persons, including Enrolled Dependents whether or not they have signed the Member's enrollment form. We and CIGNA agree that such information and records will be considered confidential.

We and CIGNA have the right to release any and all records concerning health care services which are necessary to implement and administer the terms of the Plan, for appropriate medical review or quality assessment, or as we are required to do by law or regulation. During and after the term of the Plan, we, CIGNA, and our related entities may use and transfer the information gathered under the Plan for research and analytic purposes.

For complete listings of your medical records or billing statements we recommend that you contact your health care provider. Providers may charge you reasonable fees to cover their costs for providing records or completing requested forms.

If you request medical forms or records from us, we also may charge you reasonable fees to cover costs for completing the forms or providing the records. In some cases, we or CIGNA will designate other persons or entities to request records or information from or related to you, and to release those records as necessary. Such designees have the same rights to this information as SHBP.

Examination of Covered Persons

In the event of a question or dispute regarding your right to benefits, we may require that a Network Physician of our choice examine you at our expense.

Workers' Compensation not Affected

Benefits provided under the Plan do not substitute for and do not affect any requirements for coverage by workers' compensation insurance.

Your Rights for Continuing Group Health Plan Coverage

You have the right to continue group health plan coverage if you lose Plan coverage due to a qualifying event. In this case, you may continue health care coverage for yourself, spouse or dependents; however, you or your dependents have to pay for such coverage. Review this Summary Plan Description (SPD) and other Plan documents governing your continuation coverage rights.

Employee Rights and Responsibilities

Your Rights as an Employee Enrolled in Plan Coverage

As an employee enrolled in Plan coverage, you have the right to:

- Have your eligible claims paid and notifications provided in a timely manner.
- Receive information about the Plan and the options available to you.
- Be informed of the process for filing appeals of denied claims.
- Have access to Provider information.
- Review your appeal file.
- Examine, without charge, all documents governing the Plan at the Plan Administrator's office.
- Request copies of the above documents, in writing, from the Plan Administrator (a reasonable copy fee may apply).
- Be informed by the Plan of how to continue your coverage if it would otherwise end in certain situations.

Your Responsibilities as an Employee Enrolled in Plan Coverage

This is a summary of some of the important responsibilities of employees enrolled in the Plan:

Make proper and timely premium payments. Premium payments for active employees must be made through salary deductions. Premium payments for employees on leave must be made directly to the employer. It's your responsibility to make sure that your employer (the State, school district, agency, etc.) is deducting the right amount from your paycheck for your option and coverage tier. When you are first hired, and later during each Open Enrollment (or Retiree Option Change Period), you will receive premium information.

Make accurate choices when you make your enrollment selection. After the Open Enrollment period ends, SHBP will make changes only when there is a documented administrative error. Any premium refund will be limited to 12 months of premiums and is payable only after the Plan receives documented evidence from the Member that the Plan had no liability for additional Covered Persons.

Answer surcharge questions truthfully and notify DCH, SHBP Division immediately if the answers to your surcharge questions change during the year. Intentional misrepresentation in response to surcharge questions or failure to notify DCH, SHBP Division of changes to your responses to surcharge will have

significant consequences. Active employees will lose State Health Benefit Plan coverage for 12 months beginning on the date that your false response or failure to notify is discovered. Retirees who intentionally misrepresent the response to the surcharge questions or fail to notify DCH, SHBP Division of changes to their responses will permanently lose their SHBP health insurance.

Take the time to understand how the Plan option works. You are the manager of your health care needs and, therefore, you must take the time to understand your Plan option. You also are responsible for understanding the consequences of your decisions. Carefully review this booklet and the *Active Employee Decision Guide.* Having read the documents, you can take steps to maximize your coverage.

Know when and how your participation can end. Generally, coverage ends when you no longer meet job classification or working hours requirements for eligibility or when you fail to make the proper premium payments. Coverage may also end if your employer fails to pay required contributions to the DCH, SHBP Division or if your employer decides to stop offering SHBP coverage to all employees or all employees in your job classification. For eligibility requirements and other circumstances that may result in loss of coverage, see the sections titled **Eligibility-Effective Date**.

Notify DCH, SHBP Division if you or any of your dependents are no longer eligible for coverage. If you misrepresent eligibility information when applying for coverage, during a change in coverage or when filing for benefits, or by paying for coverage on behalf of someone who is not eligible, adverse action may be taken against you by DCH or applicable enforcement agencies. Adverse actions include, but are not limited to: terminating your coverage, collection actions for all payments improperly made as a result of the misrepresentation, and criminal prosecution.

Notify DCH, SHBP Division of any address change and read all information sent to you by DCH, SHBP Division. You are responsible for reading any information we or CIGNA send to you at this address. If you are not able to review Plan information for any reason, it is your responsibility to designate a representative to act on your behalf.

Notify us if you have a qualifying event that can affect coverage or eligibility for coverage for you or a Covered Dependent. If you get married, divorced or have a baby, you may want to add or delete a dependent. You must notify your payroll location within 31 days (90 days for a newborn) of the qualifying event – or you won't be able to make the change until the next Open Enrollment period. Retirees do not have an Open Enrollment period; failure to notify the Plan within 31 days of a qualified change in status (90 days for a newborn) could permanently prohibit a retiree from making the desired change.

Furnish the DCH, SHBP Division with information required to implement Plan provisions. When you are required to provide certain information and documentation, failure to do so by the deadline will result in denial of requested coverage. DCH, SHBP Division will accept late dependent verification documentation at any time during the Plan Year and coverage will be retroactive to the qualifying event date or the first of the Plan Year, whichever is later. However, no claims will be paid until the documentation is received and approved by DCH, SHBP Division.

Update the DCH, SHBP Division on the status of eligible dependents. If your dependent child is nearing age 26 and is eligible to continue coverage as a disabled dependent, you are responsible for informing the Plan of his or her status within 31 days.

Notify the DCH, SHBP Division of any other group coverage you have, including Medicare coverage. You may be required to provide notification in advance or on request.

Your Employer's Responsibilities

Your employer – your department, agency or other entity – has specific responsibilities under the Plan, which include the following:

- Properly notifying the Plan Administrator of your employment classification.
- Timely paying all required employer contributions.

- Submit any necessary documentation in a timely and efficient manner.
- Withhold proper monthly premiums and submit them, along with the bill, to the Plan when due. If your employer does not send in premiums and documentation in a proper and timely manner, the Plan may suspend coverage benefit payments for the Employee.
- Assist in enrolling all eligible employees in the Plan within 31 days of hire unless the employee declines coverage. Then the declination form must be completed within 31 days of hire.
- Provide enrollment information to the Plan Administrator.
- Distribute Plan materials.
- Administer the Family and Medical Leave Act (FMLA) in compliance with federal law.
- Administer Military Leave in compliance with federal law.
- Administer Leave without Pay for employees.
- Collect all required premiums for employees on unpaid leave.
- Provide you with information on how you can continue coverage under the FMLA and under state leave-without-pay provisions.
- If an employee was reinstated to employment for a period of time inclusive of the applicable Open Enrollment period, the employee shall be offered the opportunity to enroll or change coverage within fifteen (15) days of the return to work.
- Provide necessary termination of coverage information to the Plan Administrator within 30 days after your employment ends or your eligibility for Plan Membership ends.
- Notify enrolled employees of Plan amendments or termination.
- Notify enrolled employees of the employer's decision to stop offering SHBP coverage to all or some of its employees.

Assistance With Your Questions

If you have any questions about your rights and responsibilities under this Plan, you should contact the Plan's Eligibility Unit at 800-610-1863.

Former Employee and Annuitant Rights and Responsibilities

Your Rights as a Former Employee and Annuitant Enrolled in Plan Coverage

As a former employee and annuitant enrolled in Plan coverage, you have the right to:

- Have your eligible claims paid and notifications provided in a timely manner.
- Receive information about the Plan and the options available to you.
- Be informed of the process for filing appeals of denied claims.
- Have access to Provider information.
- Review your appeal file.
- Examine, without charge, all documents governing the Plan at the Plan Administrator's office.
- Request copies of the above documents, in writing, from the Plan Administrator (a reasonable copy fee may apply).
- Be informed by the Plan of how to continue your coverage if it would otherwise end in certain situations.

Your Rights for Continuing Group Health Plan Coverage

You have the right to continue group health plan coverage if you lose Plan coverage due to a qualifying event. In this case, you may continue health care coverage for yourself, spouse or dependents; however, you or your dependents may have to pay for such coverage. Review this Summary Plan Description (SPD) and other Plan documents governing your continuation coverage rights.

Your Responsibilities as a Former Employee or Annuitant Enrolled in Plan Coverage

As a former employee or annuitant enrolled in Plan coverage, you can receive the most value from your coverage if you fulfill the following responsibilities:

Make proper and timely premium payments. Premium payments usually are made through: 1) the state retirement system for retirees who are receiving an annuity or 2) or by paying directly to SHBP. Coverage must be continuous. If payment is not made for coverage each month, coverage will be terminated with no right to reinstatement.

Take the time to understand how the Plan option works. You are the manager of your health care needs and, therefore, you must take the time to understand your Plan option. You also are responsible for understanding the consequences of your decisions. Carefully review this booklet and the *Retiree Health Plan Decision Guide.* Having read the documents, you can take steps to maximize your coverage.

Answer surcharge questions truthfully and notify DCH, SHBP Division immediately if the answers to your surcharge questions change during the year. Intentional misrepresentation in response to surcharge questions or failure to notify DCH, SHBP Division of changes to your responses to surcharge questions will have significant consequences. Former employees and annuitants who intentionally misrepresent the response to the surcharge questions or fail to notify DCH, SHBP Division of changes to their responses will permanently lose their SHBP health insurance.

Notify DCH, SHBP Division if you or any of your dependents are no longer eligible for coverage. If you misrepresent eligibility information when applying for coverage, during a change in coverage or when filing for benefits, or by paying for coverage on behalf of someone who is not eligible, adverse action may be taken against you by DCH or applicable enforcement agencies. Adverse actions include, but are not limited to: terminating your coverage, collection actions for all payments improperly made as a result of the misrepresentation, and criminal prosecution.

Notify DCH, SHBP Division of any address change and read all information sent to you by DCH, SHBP Division. You are responsible for reading any information we or CIGNA send to you at this address. If you are not able to review Plan information for any reason, it is your responsibility to designate a representative to act on your behalf.

Notify DCH, SHBP Division if you have a qualifying event that can affect coverage or eligibility for coverage for you or a Covered Dependent. If you get married, divorced or have a baby, you may want to add or delete a dependent. Former employees and annuitants do not have an Open Enrollment period; failure to notify DCH, SHBP Division within 31 days (90 days for a newborn) of a qualified change in status could permanently prohibit a former employee or annuitant from making the desired change.

Furnish DCH, SHBP Division with information required to implement Plan provisions. When you are required to provide certain information and documentation, failure to do so by the deadline will result in denial of requested coverage. For example, if you do not make the request to add a new child within 31 days of the qualifying event (90 days for a newborn), your request for coverage of the new child will be denied.

DCH, SHBP Division will accept late dependent verification documentation at any time during the Plan Year and coverage will be retroactive to the qualifying event date or the first of the Plan Year, whichever is later. However, no claims will be paid until the documentation is received and approved by SHBP.

Notify the DCH, SHBP Division of any other group coverage you have, including Medicare coverage. You may be required to provide notification in advance or on request.

Assistance With Your Questions

If you have any questions about your rights and responsibilities under this Plan, you should contact the Plan's Eligibility Unit at 800-610-1863.

Notice of Provider Directory/Networks

You may access a list of Providers who participate in the network by visiting myCIGNA.com or by calling the toll-free telephone number on your ID card.

Notice Regarding Provider/Pharmacy Directories and Provider/Pharmacy Networks

Your Participating Provider/Pharmacy networks consist of a group of local medical practitioners, and Hospitals, of varied specialties as well as general practice or a group of local Pharmacies who are contracted with CIGNA.

FDRL32

CIGNA LEGAL NOTICES

Qualified Medical Child Support Order (QMCSO)

Eligibility for Coverage Under a QMCSO

If a Qualified Medical Child Support Order (QMCSO) is issued for your child, that child will be eligible for coverage as required by the order and you will not be considered a Late Entrant for Dependent Insurance.

You must notify your employer and elect coverage for that child and yourself, if you are not already enrolled, within 31 days of the QMCSO being issued.

Qualified Medical Child Support Order Defined

A Qualified Medical Child Support Order is a judgment, decree or order (including approval of a settlement agreement) or administrative notice, which is issued pursuant to a state domestic relations law (including a community property law), or to an administrative process, which provides for child support or provides for health benefit coverage to such child and relates to benefits under the group health plan, and satisfies all of the following:

1. the order recognizes or creates a child's right to receive group health benefits for which a participant or beneficiary is eligible;
2. the order specifies your name and last known address, and the child's name and last known address, except that the name and address of an official of a state or political subdivision may be substituted for the child's mailing address;
3. the order provides a description of the coverage to be provided, or the manner in which the type of coverage is to be determined;
4. the order states the period to which it applies; and
5. if the order is a National Medical Support Notice completed in accordance with the Child Support Performance and Incentive Act of 1998, such Notice meets the requirements above.

The QMCSO may not require the health insurance policy to provide coverage for any type or form of benefit or option not otherwise provided under the policy, except that an order may require a plan to comply with State laws regarding health care coverage.

Payment of Benefits

Any payment of benefits in reimbursement for Covered Expenses paid by the child, or the child's custodial parent or legal guardian, shall be made to the child, the child's custodial parent or legal guardian, or a state official whose name and address have been substituted for the name and address of the child.

FDRL2 V1

Special Enrollment Rights Under the Health Insurance Portability & Accountability Act (HIPAA)

If you or your eligible Dependent(s) experience a special enrollment qualifying event as described below, you or your eligible Dependent(s) may be entitled to enroll in the Plan outside of a designated enrollment period upon the occurrence of one of the special enrollment qualifying events listed below. If you are already enrolled in the Plan, you may request enrollment for you and your eligible Dependent(s) under a different option offered by the Employer for which you are currently eligible. If you are not already enrolled in the Plan, you must request special enrollment for yourself in addition to your eligible Dependent(s). You and all of your eligible Dependent(s) must be covered under the same option. The special enrollment qualifying events include:

- **Acquiring a new Dependent.** If you acquire a new Dependent(s) through marriage, birth, adoption or placement for adoption, you may request special enrollment to enroll and/or change your coverage tier to add eligible dependents.
- **Loss of eligibility for other coverage (excluding continuation coverage).** If eligibility under another group plan was lost, you and all of your eligible Dependent(s) may request special enrollment in this Plan. If required by the Plan, when enrollment in this Plan was previously declined, it must have been declined in writing with a statement that the reason for declining enrollment was due to other health coverage. This provision applies to loss of eligibility as a result of any of the following:
  - divorce;
  - cessation of Dependent status (such as reaching the limiting age);
  - death of the Employee;
  - termination of employment;
  - reduction in work hours to below the minimum required for eligibility;
  - you or your Dependent(s) no longer reside, live or work in the other plan's network service area and no other coverage is available under the other plan;
  - you or your Dependent(s) incur a claim which meets or exceeds the lifetime maximum limit that is applicable to all benefits offered under the other plan; or
  - the other plan no longer offers any benefits to a class of similarly situated individuals.
- **Termination of employer contributions (excluding continuation coverage).** If a current or former employer ceases all contributions toward the Employee's or Dependent's other coverage, special enrollment may be requested in this Plan for you and all of your eligible Dependent(s).
- **Exhaustion of COBRA or other continuation coverage.** Special enrollment may be requested in this Plan for you and all of your eligible Dependent(s) upon exhaustion of COBRA or other continuation coverage. If you or your Dependent(s) elect COBRA or other continuation coverage following loss of coverage under another plan, the COBRA or other continuation coverage must be exhausted before any special enrollment rights exist under this Plan. An individual is considered to have exhausted COBRA or other continuation coverage only if such coverage ceases: (a) due to failure of the employer or other responsible entity to remit premiums on a timely basis; (b) when the person no longer resides or works in the other plan's service area and there is no other COBRA or continuation coverage available under the plan; or (c) when the individual incurs a claim that would meet or exceed a lifetime maximum limit on all benefits and there is no other COBRA or other continuation coverage available to the individual. This does not include termination of an employer's limited period of contributions toward COBRA or other continuation coverage as provided under any severance or other agreement.

FDRL3 V3

Eligibility for employment assistance under State Medicaid or Children's Health Insurance Program (CHIP). If you and/or your Dependent(s) become eligible for assistance with group health plan premium payments under a state Medicaid or CHIP plan, you may request special enrollment for yourself and any

affected Dependent(s) who are not already enrolled in the Plan. You must request enrollment within 60 days after the date you are determined to be eligible for assistance.

Except as stated above, special enrollment must be requested within 30 days after the occurrence of the special enrollment qualifying event. If the special enrollment qualifying event is the birth or adoption of a Dependent child, coverage will be effective immediately on the date of birth, adoption or placement for adoption. Coverage with regard to any other special enrollment qualifying event will be effective on the first day of the calendar month following receipt of the request for special enrollment.

Individuals who enroll in the Plan due to a special enrollment qualifying event will not be considered Late Entrants.

Domestic Partners and their children (if not legal children of the Employee) are not eligible for special enrollment.

FDRL4 V2

Effect of Section 125 Regulations on This Plan

Your Employer has chosen to administer this Plan in accordance with Section 125 Regulations of the Internal Revenue Code. Per this regulation, you may agree to a pretax salary reduction put toward the cost of your benefits. Otherwise you will receive your taxable earnings as cash (salary).

Provisions in this certificate which allow for enrollment or coverage changes not consistent with Section 125 Regulations are superseded by this section.

Coverage Elections

Per Section 125 Regulations, you are generally allowed to enroll for or change coverage only before each annual benefit period. However, exceptions are allowed if you enroll for or change coverage within 30 days of the following:

- the date you meet Special Enrollment criteria per federal requirements as described in the Section entitled “Eligibility – Effective Date/Exception to Late Entrant Definition”; or
- the date you meet criteria shown in the section entitled “Change of Status.”

GM 6000 SCT125V1

Eligibility for Coverage for Adopted Children

Any child under the age of 18 who is adopted by you, including a child who is placed with you for adoption, will be eligible for Dependent Insurance upon the date of placement with you. A child will be considered placed for adoption when you become legally obligated to support that child, totally or partially, prior to that child’s adoption.

If a child placed for adoption is not adopted, all health coverage ceases when the placement ends, and will not be continued.

The provisions in the “Exception for Newborns” section of this document that describe requirements for enrollment and effective date of insurance will also apply to an adopted child or a child placed with you for adoption.

FDRL6

Federal Tax Implications for Dependent Coverage

Premium payments for Dependent health insurance are usually exempt from federal income tax. Generally, if you can claim an individual as a Dependent for purposes of federal income tax, then the premium for that Dependent’s health insurance coverage will not be taxable to you as income. However, in the rare instance

that you cover an individual under your health insurance who does not meet the federal definition of a Dependent, the premium may be taxable to you as income. If you have questions concerning your specific situation, you should consult your own tax consultant or attorney.

FDRL7

Coverage for Maternity Hospital Stay

Under federal law, group health plans and health insurance issuers offering group health insurance coverage generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by cesarean section. However, the plan or issuer may pay for a shorter stay if the attending provider (*e.g.,* your physician, nurse midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

Also, under federal law, plans and issuers may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, a plan or issuer may not, under federal law, require that a physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain precertification.

Please review this Plan for further details on the specific coverage available to you and your Dependents.

FDRL8

Women's Health and Cancer Rights Act (WHCRA)

Do you know that your plan, as required by the Women's Health and Cancer Rights Act of 1998, provides benefits for mastectomy-related services including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy, including lymphedema? Call Member Services at the toll free number listed on your ID card for more information.

FDRL51

Creditable Coverage

Creditable Coverage will include coverage under any of the following: A self-insured employer group health plan; Individual or group health insurance indemnity or HMO plans; Part A or Part B of Medicare; Medicaid, except coverage solely for pediatric vaccines; A health plan for certain Members of the uniformed armed services and their dependents, including the Commissioned Corps of the National Oceanic and Atmospheric Administration and of the Public Health Service; A medical care program of the Indian Health Service or of a tribal organization; A state health benefits risk pool; The Federal Employees Health Benefits Program; A public health plan established by a State, the U.S. government, or a foreign country; the Peace Corps Act; Or a State Children's Health Insurance Program.

Obtaining a Certificate of Creditable Coverage Under This Plan

Upon loss of coverage under this Plan, a Certificate of Creditable Coverage will be mailed to each terminating individual at the last address on file. You or your dependent may also request a Certificate of Creditable Coverage, without charge, at any time while enrolled in the Plan and for 24 months following termination of coverage. You may need this document as evidence of your prior coverage to reduce any pre-existing condition limitation period under another plan, to help you get special enrollment in another plan, or to obtain certain types of individual health coverage even if you have health problems. To obtain a Certificate of Creditable Coverage, contact the SHBP Eligibility Unit.

FDRL12

Requirements of Family and Medical Leave Act of 1993

Any provisions of the policy that provide for: (a) continuation of insurance during a leave of absence; and (b) reinstatement of insurance following a return to Active Service; are modified by the following provisions of the federal Family and Medical Leave Act of 1993, where applicable:

A. Continuation of Health Insurance During Leave

Your health insurance will be continued during a leave of absence if:

- that leave qualifies as a leave of absence under the Family and Medical Leave Act of 1993; and
- you are an eligible Employee under the terms of that Act.

The cost of your health insurance during such leave must be paid, whether entirely by your employer or in part by you and your employer.

B. Reinstatement of Canceled Insurance Following Leave

Upon your return to Active Service following a leave of absence that qualifies under the Family and Medical Leave Act of 1993, any canceled insurance (health, life or disability) will be reinstated as of the date of your return.

You will not be required to satisfy any eligibility or benefit waiting period to the extent that it has been satisfied prior to the start of such leave of absence.

Your Employer will give you detailed information about the Family and Medical Leave Act of 1993.

GM6000 TRM191V1

Continuing Coverage Under Family and Medical leave Act (FMLA)

You may continue medical coverage for yourself and your dependents for up to 12 weeks after the start of your leave for specific medical and/or family medical reasons if your employer has approved your leave as FMLA leave. Forms for continuing your coverage are available from your personnel/payroll office.

During FMLA leave without pay, you will pay the same premium amount you paid while actively working, but you must send your premium payment directly to your employer. How FMLA affects your coverage depends on the circumstances involving your leave.

If you have this situation…	The impact is this…
• Choose not to continue coverage while on leave	• Claims will not be paid by SHBP for the period after coverage terminates and while you remain on leave. You are responsible for paying Providers. • You must resume coverage when you return to work.
• Open Enrollment period occurs while on leave	• If you continue coverage while on leave, you may change coverage as permitted during Open Enrollment. • If you do not continue coverage while on leave, contact your employer for Open Enrollment information.
• Do not return to work after your leave ends and you have paid your premiums directly to your employer during your leave	• You may be eligible to continue your health benefits through COBRA.

Continuing Coverage During Military Leave

If you are on certain kinds of military leave described by federal law, you and your dependents may continue coverage by paying the same premiums you paid while actively working. However, these premiums must be paid directly to your employer. Your employer is responsible for approving your military leave and collecting premiums from you.

You may elect to discontinue coverage while on leave. The DCH, SHBP Division will reinstate your coverage when you return to employment after military service. However, for the time period allowed by the Veteran's Administration, the Plan does not cover care for a Participant's illness or injury that the Secretary of Veterans' Affairs determines was acquired or aggravated during the military leave.

Uniformed Services Employment and Re-Employment Rights Act of 1994 (USERRA)

The Uniformed Services Employment and Re-employment Rights Act of 1994 (USERRA) sets requirements for continuation of health coverage and re-employment in regard to an Employee's military leave of absence. These requirements apply to medical and dental coverage for you and your Dependents. They do not apply to any Life, Short-term or Long-term Disability or Accidental Death & Dismemberment coverage you may have.

Continuation of Coverage

For leaves of less than 31 days, coverage will continue as described in the Termination section regarding Leave of Absence.

For leaves of 31 days or more, you may continue coverage for yourself and your Dependents as follows:

You may continue benefits by paying the required premium to SHBP, until the earliest of the following:

- 24 months from the last day of employment with the Employer;
- the day after you fail to return to work; and
- the date the policy cancels.

SHBP may charge you and your Dependents up to 102% of the total premium.

Reinstatement of Benefits (applicable to all coverages)

If your coverage ends during the leave of absence because you do not elect USERRA and you are reemployed by your current Employer, coverage for you and your Dependents may be reinstated if (a) you gave your employer advance written or verbal notice of your military service leave, and (b) the duration of all military leaves while you are employed with your current Employer does not exceed 5 years.

You and your Dependents will be subject to only the balance of a waiting period that was not yet satisfied before the leave began. However, if an Injury or Sickness occurs or is aggravated during the military leave, full Plan limitations will apply.

If your coverage under this plan terminates as a result of your eligibility for military medical and dental coverage and your order to active duty is canceled before your active duty service commences, these reinstatement rights will continue to apply.

FDRL58

COBRA Continuation Rights Under Federal Law

For You and Your Dependents

When Coverage may be Continued

Certain situations allow you to continue your SHBP coverage temporarily. If you have eight or more Years of Service, you may have additional rights to continue coverage.

Unpaid Leaves of Absence

If you are an active employee on an approved unpaid leave, you may be able to continue your current coverage for up to 12 calendar months – or longer for military leave.

Unpaid leave is available for:

- Disability/illness – more details below.
- Educational instruction.
- Employee's convenience.
- Employer's convenience.
- Family medical reasons as provided under the Family and Medical Leave Act (FMLA)
- Military duty (emergency and voluntary)
- Suspension of employment.

You will have to meet certain requirements for each leave type and your personnel/payroll office can provide you with the necessary information, including premium rates and a *Request to Continue Health Benefits During Leave of Absence Without Pay* form. Also, most leave types require supporting documentation which you will supply to your employer.

You can apply for continued coverage within 31 days after starting an unpaid leave.

Continuing Coverage During Approved Disability Leave

In case you become disabled while an active employee, the Plan has provisions that may allow you to continue coverage, which are described in the table below:

Because of a disability, you have this situation:	You will be affected in this way:
You are Totally Disabled and are on an approved disability leave. OR You return to work on a part-time basis before the end of your approved disability leave and before returning to full-time work.	You will be eligible to continue health benefits for up to 12 months. You will pay the same premium amount you paid while actively working, but you must pay premiums directly to your employer. Coverage is limited to the disability period that your Physician certifies. You must provide documentation of the applicable disability period to your employer.

If you are a disabled retired Member, refer to pages 89-99 for more information on how your coverage may be affected.

If You Leave Your Job With Less than 8 Years of Service

This chart shows how your coverage would be affected if you were to leave your job with less than 8 Years of Service. Please see pages 89-99 about leaving your job with 8 or more Years of Service.

If you have this situation:	You will be affected in this way:
• Leave your job • Take another job with your employer that does not qualify you for coverage • Move to part-time status with hours below the minimum required for eligibility • Are laid off or otherwise terminate employment	You can continue coverage for up to 18 months under COBRA provisions

In the Event of Your Death During Active Employment

As described below, surviving dependents may continue coverage temporarily through COBRA. Note: If your surviving enrolled dependents are able to receive a retirement plan annuity (a monthly check), see pages 89-99 for important information about extra rights they may have.

The cost of continuing coverage as a surviving dependent with an annuity may be much lower than the cost of COBRA continuation. Surviving dependents must apply for survivor continuation coverage within ninety days of the Member's death. If a surviving dependent chooses survivor continuation coverage, he or she waives the right to continue coverage under the COBRA rules.

See pages 93 for information on survivor coverage in the event of the death of a former employee with more than 8 Years of Service.

Notification Requirements and Election Period for Continuation Coverage under Federal Law (COBRA)

The Member or other Qualified Beneficiary must notify DCH, SHBP Division within 60 days of the Member's divorce or an Enrolled Dependent's loss of eligibility as an Enrolled Dependent. If the Member or other Qualified Beneficiary fails to notify DCH, SHBP Division of these events within the 60 day period, there is no right to continue coverage under COBRA. In addition, failure to notify DCH, SHBP Division that a dependent has lost eligibility is an intentional misrepresentation, and will be grounds for terminating coverage for the Member and the dependent. If a Member or other Qualified Beneficiary is already continuing coverage under COBRA, the Member or other Qualified Beneficiary must notify the DCH, SHBP Division within 60 days of the birth or adoption of a child. Failure to notify the DCH, SHBP Division within the 60 day period will result in loss of the right to add the new child to the COBRA coverage.

Once DCH, SHBP Division receives notification of divorce or loss of dependent eligibility from the Member or Qualified Beneficiary, coverage will be terminated for the former spouse or dependent who lost eligibility retroactive to the end of the month in which the qualifying event occurred. A COBRA election notice will be mailed to the Member or Qualified Beneficiary. If a complete, signed election of continuation coverage is submitted to DCH, SHBP Division by the later of 60 days after the qualifying event occurs or 60 days after the Qualified Beneficiary receives the COBRA election form from SHBP, COBRA coverage will be provided upon payment of required COBRA premiums.

The initial premium due to SHBP must be paid on or before the 45th day after electing continuation.

Notification Requirements for Disability Determination or Change in Disability Status

The Member or other Qualified Beneficiary must notify DCH, SHBP Division as described under "Terminating Events for Continuation Coverage under federal law (COBRA)", subsection A. below.

The notice requirements will be satisfied by providing written notice to the DCH, SHBP Division at SHBP, P.O. Box 1990, Atlanta, GA 30301-1990. The contents of the notice must be such that SHBP is able to determine the covered employee and Qualified Beneficiary or Qualified Beneficiaries, the qualifying event or disability, and the date on which the qualifying event occurred.
After providing notice to the DCH, SHBP Division, the Qualified Beneficiary shall receive the continuation coverage and election notice. Continuation coverage must be elected by the later of 60 days after the qualifying event occurs; or 60 days after the Qualified Beneficiary receives notice of the continuation right from SHBP.

The Qualified Beneficiary's initial premium due to SHBP must be paid on or before the 45th day after electing continuation.

The Trade Act of 2002 amended COBRA to provide for a special second 60-day COBRA election period for certain Members who have experienced a termination or reduction of hours and who lose group health plan coverage as a result. The special second COBRA election period is available only to a very limited group of individuals: generally, those who are receiving trade adjustment assistance (TAA) or 'alternative trade adjustment assistance' under a federal law called the Trade Act of 1974. These Members are entitled to a second opportunity to elect COBRA coverage for themselves and certain family members (if they did not already elect COBRA coverage), but only within a limited period of 60 days from the first day of the month when an individual begins receiving TAA (or would be eligible to receive TAA but for the requirement that unemployment benefits be exhausted) and only during the six months immediately after their group health plan coverage ended.

If a Member qualifies or may qualify for assistance under the Trade Act of 1974, he or she should contact SHBP for additional information. The Member must contact SHBP promptly after qualifying for assistance under the Trade Act of 1974 or the Member will lose his or her special COBRA rights. COBRA coverage

elected during the special second election period is not retroactive to the date that Plan coverage was lost, but begins on the first day of the special second election period.

Terminating Events for Continuation Coverage under Federal Law (When COBRA Coverage Ends)

COBRA continuation coverage under the Plan will end on the earliest of the following applicable dates:

A. Eighteen months from the date of the qualifying event, if the Qualified Beneficiary's coverage would have ended because the Member's employment was terminated or hours were reduced (i.e., qualifying event A.).

   If a Qualified Beneficiary is determined to have been disabled under the Social Security Act at anytime within the first 60 days of continuation coverage for qualifying event A, then the Qualified Beneficiary may elect an additional 11 months of continuation coverage (for a total of 29 months of continued coverage) subject to the following condition: (i) notice of such disability must be provided within 60 days after the determination of the disability, and in no event later than the end of the first 18 months; (ii) the Qualified Beneficiary must agree to pay any increase in the required premium for the additional 11 months; and (iii) if the Qualified Beneficiary entitled to the 11 months of coverage has non-disabled family members who are also Qualified Beneficiaries, then those non-disabled Qualified Beneficiaries are also entitled to the additional 11 months of continuation coverage. Notice of any final determination that the Qualified Beneficiary is no longer disabled must be provided within 30 days of such determination. Thereafter, continuation coverage may be terminated by the Plan on the first day of the month that begins more than 30 days after the date of that determination.

B. Thirty-six months from the date of the qualifying event for an Enrolled Dependent whose coverage ended because of the death of the Member, divorce of the Member, or loss of eligibility by an Enrolled Dependent who is a child (i.e. qualifying events B., C., or D.).

C. For the Enrolled Dependents of a Member who was entitled to Medicare prior to a qualifying event that was due to either the termination of employment or work hours being reduced, eighteen months from the date of the qualifying event, or, 36 months from the date of the Member's Medicare entitlement, whichever is later.

D. The date coverage terminates under the Plan for failure to make timely payment of the premium.

E. The date, after electing continuation coverage, that coverage is first obtained under any other group health plan. If such coverage contains a limitation or exclusion with respect to any pre-existing condition, continuation shall end on the date such limitation or exclusion ends. The other group health coverage shall be primary for all health services except those health services that are subject to the pre-existing condition limitation or exclusion.

F. The date, after electing continuation coverage, that the Qualified Beneficiary first becomes entitled to Medicare, except that this shall not apply in the event that coverage was terminated because the Plan Sponsor filed for bankruptcy, (i.e. qualifying event F.).

G. The date the entire Plan ends or the date the employer stops offering SHBP coverage.

H. The date coverage would otherwise terminate under the Plan as described in this section under the heading *Events Ending Your Coverage*.

If a Qualified Beneficiary is entitled to 18 months of continuation and a second qualifying event occurs during that time, the Qualified Beneficiary's coverage may be extended up to a maximum of 36 months from the date coverage ended because employment was terminated or hours were reduced below the minimum hours for Plan eligibility. If the Qualified Beneficiary was entitled to continuation because the Plan Sponsor filed for bankruptcy, (i.e. qualifying event F.) and the retired Member dies during the continuation period, then the other Qualified Beneficiaries shall also be entitled to continue coverage for 36 months from the date of the Member's

death. Terminating events B. through G. described in this section will apply during the extended continuation period.

Continuation coverage for Qualified Beneficiaries whose continuation coverage terminates because the Member becomes entitled to Medicare may be extended for an additional period of time. Such Qualified Beneficiaries should contact the DCH, SHBP Division for information regarding the continuation period.

Continuation of Coverage

If your coverage ends under the Plan, you may be entitled to elect continuation coverage (coverage that continues on in some form) in accordance with federal law.

Continuation coverage under COBRA (the federal Consolidated Omnibus Budget Reconciliation Act) is available only to Plans that are subject to the terms of COBRA. You can contact your Plan Administrator to determine if we are subject to the provisions of COBRA.

If you selected continuation coverage under a prior plan which was then replaced by coverage under this Plan, continuation coverage will end as scheduled under the prior plan or in accordance with the terminating events listed below, whichever is earlier.

Continuation Coverage under Federal Law (COBRA)

Much of the language in this section comes from the federal law that governs continuation coverage.

In order to be eligible for continuation coverage under federal law, you must meet the definition of a "Qualified Beneficiary". A Qualified Beneficiary is any of the following persons who was covered under the Plan on the day before a qualifying event:

- A Member.
- A Member's Enrolled Dependent, including with respect to the Member's children, a child born to or placed for adoption with the Member during a period of continuation coverage under federal law.
- A Member's former spouse.

Qualifying Events for Continuation Coverage under Federal Law (COBRA)

If the coverage of a Qualified Beneficiary terminates due to one of the following qualifying events, then the Qualified Beneficiary is entitled to continue coverage. The Qualified Beneficiary is entitled to elect to continue the same coverage that she or he had on the day before the qualifying event. When a Qualified Beneficiary has elected COBRA continuation coverage, that coverage can be extended due to a second qualifying event.

The qualifying events are:

- Termination of the Member from employment with us, for any reason other than gross misconduct reduction of hours below the minimum hours required for eligibility, or transfer to a position for which SHBP coverage is not offered; or
- Death of the Member; or
- Divorce from the Member; or
- Loss of eligibility by an Enrolled Dependent who is a child; or
- Entitlement of the Member to Medicare benefits; or
- The Plan Sponsor filing for bankruptcy, under Title XI, United States Code, on or after July 1, 1986, but only for a retired Member and his or her Enrolled Dependents. This is also a qualifying event for any retired Member and his or her Enrolled Dependents if there is a substantial elimination of coverage within one year before or after the date the bankruptcy was filed.

Interaction With Other Continuation Benefits

You may be eligible for other continuation benefits under state law. Refer to the Termination section for any other continuation benefits.

FDRL26 V1

When You Have a Complaint or an Appeal

For the purposes of this section, any reference to "you," "your," or "Member" also refers to a representative or provider designated by you to act on your behalf, unless otherwise noted.

"Physician Reviewers" are licensed Physicians depending on the care, service or treatment under review.

We want you to be completely satisfied with the care you receive. That is why we have established a process for addressing your concerns and solving your problems.

Start With Member Services

We are here to listen and help. If you have a concern regarding a person, a service, the quality of care, or contractual benefits, you may call the toll-free number on your benefit Identification card, explanation of benefits, or claim form and explain your concern to one of our Member Services representatives. You may also express that concern in writing.

We will do our best to resolve the matter on your initial contact. If we need more time to review or investigate your concern, we will get back to you as soon as possible, but in any case within 30 days. If you are not satisfied with the results of a coverage decision, you may start the appeals procedure.

Appeal Process – How to Appeal an Eligibility Decision

The DCH, SHBP Division will handle all eligibility appeals. There are three steps in the appeal process:

STEP 1 – TELEPHONE REVIEW

Call the SHBP's eligibility unit and ask for a review within 90 days of the eligibility denial. If you disagree with the results of the review, you may file a written request for an Administrative Review. Contact the Eligibility Unit within 90 days of when the Plan advises you that your request cannot be approved.

Note: Any issue regarding the Plan's eligibility or participation should first be addressed to the Eligibility Unit and then through the Administrative Review process.

STEP II – ADMINISTRATIVE REVIEW

To file a request for Administrative Review, complete all applicable Sections on the Admin Review form, sign the form and send a copy of the denied action if applicable. Any additional facts or materials that are pertinent to the case should be attached and submitted with this form within 90 days of the denied action concerning your eligibility. Generally a decision is reached within 60 days of receipt unless additional information is needed.

STEP III – FORMAL APPEAL

If your request for Administrative Review is denied, you may file a Formal Appeal, which must be postmarked within 60 days following the date of the Administrative Review decision. To file a Formal Appeal, you must complete the applicable form and attach a copy of the decision of the Administrative Review. Instructions are on the Formal Appeal form. Generally a decision is issued within 90 days following receipt; however, the number of days may be extended by notice from the DCH, SHBP Division. If your claim has been denied because you were not eligible for coverage under the plan, a decision will be reached within 30 days of receipt unless additional information is needed. Please indicate on the appeal form that your claim was denied. The written notice of the decision by the Committee is the final step in the administrative proceedings and will exhaust all administrative remedies.

Please forward all written requests for Eligibility Administrative Reviews and Formal Appeals along with a completed appeal form to: State Health Benefit Plan, Vendor Program Management Unit, P. O. Box 1990,

Atlanta, GA 30301. The appeal forms are available through your Personnel/Payroll office, website address www.dch.georgia.gov/shbp or directly from the DCH, SHBP Division. All member correspondence sent to the DCH, SHBP Division should include the enrolled member's Social Security Number (SSN) to prevent a delay in processing your request.

Appeals Procedure

CIGNA has a two-step appeals procedure for coverage decisions. To initiate an appeal, you must submit a request for an appeal in writing to CIGNA within 365 days of receipt of a denial notice. You should state the reason why you feel your appeal should be approved and include any information supporting your appeal. If you are unable or choose not to write, you may ask CIGNA to register your appeal by telephone. Call or write us at the toll-free number on your benefit Identification card, explanation of benefits, or claim form.

Level-One Appeal

Your appeal will be reviewed and the decision made by someone not involved in the initial decision. Appeals involving Medical Necessity or clinical appropriateness will be considered by a health care professional.

For level-one appeals, we will respond in writing with a decision within 15 calendar days after we receive an appeal for a required preservice or concurrent care coverage determination, and within 30 calendar days after we received an appeal for a postservice coverage determination. If more time or information is needed to make the determination, we will notify you in writing to request an extension of up to 15 calendar days and to specify any additional information needed to complete the review.

You may request that the appeal process be expedited if, (a) the time frames under this process would seriously jeopardize your life, health or ability to regain maximum functionality or in the opinion of your Physician would cause you severe pain which cannot be managed without the requested services; or (b) your appeal involves nonauthorization of an admission or continuing inpatient Hospital stay. CIGNA's Physician reviewer, in consultation with the treating Physician, will decide if an expedited appeal is necessary. When an appeal is expedited, CIGNA will respond orally with a decision within 72 hours, followed up in writing.

FDRL37

Level-Two Appeal

If you are dissatisfied with our level-one appeal decision, you may request a second review. To initiate a level-two appeal, follow the same process required for a level-one appeal.

Most requests for a second review will be conducted by the Committee, which consists of a minimum of three people. Anyone involved in the prior decision may not vote on the Committee. For appeals involving Medical Necessity or clinical appropriateness the Committee will consult with at least one Physician in the same or similar specialty as the care under consideration, as determined by CIGNA's Physician reviewer. You may present your situation to the Committee in person or by conference call.

For level-two appeals we will acknowledge in writing that we have received your request and schedule a Committee review. For required preservice and concurrent care coverage determinations the Committee review will be completed within 15 calendar days and for post service claims, the Committee review will be completed within 30 calendar days. If more time or information is needed to make the determination, we will notify you in writing to request an extension of up to 15 calendar days and to specify any additional information needed by the Committee to complete the review. You will be notified in writing of the Committee's decision within 5 business days after the Committee meeting, and within the Committee review time frames above if the Committee does not approve the requested coverage.

You may request that the appeal process be expedited if, (a) the time frames under this process would seriously jeopardize your life, health or ability to regain maximum functionality or in the opinion of your Physician, would cause you severe pain which cannot be managed without the requested services; or (b) your

appeal involves nonauthorization of an admission or continuing inpatient Hospital stay. CIGNA's Physician reviewer, in consultation with the treating Physician, will decide if an expedited appeal is necessary. When an appeal is expedited, CIGNA will respond orally with a decision within 72 hours, followed up in writing.

Voluntary External Review Program

If a final determination to deny benefits is made, you may choose to participate in our voluntary external review program. This program only applies if the decision is based on either of the following:

- Clinical reasons.
- The exclusion for Experimental, Investigational or Unproven Services.

NOTE: The external review program is not available if the coverage determinations are based on explicit benefit exclusions or defined benefit limits. Therefore, the second level appeal decision is final. Contact CIGNA at the telephone number shown on your ID card for more information on the voluntary external review program.

Notice of Benefit Determination on Appeal

Every notice of a determination on appeal will be provided in writing or electronically and, if an adverse determination, will include: (1) the specific reason or reasons for the adverse determination; (2) reference to the specific plan provisions on which the determination is based; (3) a statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other Relevant Information as defined; (4) a statement describing any voluntary appeal procedures offered by the plan; (5) upon request and free of charge, a copy of any internal rule, guideline, protocol or other similar criterion that was relied upon in making the adverse determination regarding your appeal, and an explanation of the scientific or clinical judgment for a determination that is based on a Medical Necessity, experimental treatment or other similar exclusion or limit.

Relevant Information

Relevant information is any document, record or other information which: (a) was relied upon in making the benefit determination; (b) was submitted, considered or generated in the course of making the benefit determination, without regard to whether such document, record, or other information was relied upon in making the benefit determination; (c) demonstrates compliance with the administrative processes and safeguards required by federal law in making the benefit determination; or (d) constitutes a statement of policy or guidance with respect to the plan concerning the denied treatment option or benefit for the claimant's diagnosis, without regard to whether such advice or statement was relied upon in making the benefit determination.

Definitions

Active Service

You will be considered in Active Service:

- on any of your employer's scheduled work days if you are performing the regular duties of your work on a full-time basis on that day either at your employer's place of business or at some location to which you are required to travel for your employer's business.
- on a day which is not one of your employer's scheduled work days if you were in Active Service on the preceding scheduled work day.

DFS1

Alternate Facility

A health care facility that is not a Hospital and that provides one or more of the following services on an outpatient basis, as permitted by law:

- Surgical services.
- Emergency Health Services.
- Rehabilitative, laboratory, diagnostic or therapeutic services.

An Alternate Facility may also provide Mental Health Services or Substance Use Disorder Services on an outpatient or inpatient basis.

Amendment

Any attached written description of additional or alternative provisions to the Plan. Amendments are effective only when signed by the SHBP and CIGNA. Amendments are subject to all conditions, limitations and exclusions of the Plan, except for those that are specifically amended.

Ancillary Charge

A charge, in addition to the Coinsurance, that you are required to pay when a covered Prescription Drug Product is dispensed at your request, when a chemically equivalent Prescription Drug Product is available on a lower tier. For Prescription Drug Products from Network Pharmacies, the Ancillary Charge is calculated as the difference between the Prescription Drug Cost or MAC list price for Network Pharmacies for the brand name Prescription Drug Product on the higher tier, and the Prescription Drug Cost or MAC list price of the chemically equivalent Prescription Drug Product available on the lower tier.

Annuity

The monthly retirement check that an individual receives who has met the requirements of a state sponsored retirement system.

Annuitant

An individual who is enrolled in the Plan at the time he/she retires and is immediately eligible to draw a retirement annuity from a State of Georgia sponsored Retirement Systems

Annuitant Premiums

The health premium that is deducted from the retirement check that retirees who are enrolled in the Plan and are drawing a retirement annuity from a State of Georgia sponsored Retirement Systems. Currently this premium is the same as an active employee.

Annual Deductible

The amount of Eligible Expenses you must pay for Covered Health Services in a Plan year before the Plan will begin paying for Benefits in that Plan year. This Plan has a Network Deductible and an Out-of-Network Deductible.

Autism Spectrum Disorders

A group of neurobiological disorders that includes *Autistic Disorder, Rhett's Syndrome, Asperger's Disorder, Childhood Disintegrated Disorder, and a Pervasive Development Disorders Not Otherwise Specified (PDDNOS)*.

Bed and Board

The term Bed and Board includes all charges made by a Hospital on its own behalf for room and meals and for all general services and activities needed for the care of registered bed patients.

DFS14

Benefits

Your right to payment for Covered Health Services that are available under the Plan. Your right to Benefits is subject to the terms, conditions, limitations and exclusions of the Plan, including this SPD and any attached Riders and Amendments.

Brand-name

A Prescription Drug Product: (1) which is manufactured and marketed under a trademark or name by a specific drug manufacturer; or (2) that CIGNA identifies as a Brand-name product, based on available data resources including, but not limited to, First DataBank, that classify drugs as either brand or generic based on a number of factors. You should know that all products identified as a "brand name" by the manufacturer, pharmacy, or your Physician may not be classified as Brand-name by CIGNA.

Charges

The term "charges" means the actual billed charges; except when the provider has contracted directly or indirectly with CIGNA for a different amount.

DFS940

Chiropractic Care

The term Chiropractic Care means the conservative management of neuromusculoskeletal conditions through manipulation and ancillary physiological treatment rendered to specific joints to restore motion, reduce pain and improve function.

DFS1689

Claims Administrator

The company (including its affiliates) that provides certain claim administration services for the Plan. CIGNA is the Plan's Claims Administrator.

Clinical Cancer Trial Services

Clinical trials study the effectiveness of new interventions. There are different types of cancer clinical trials such as:

- prevention trials;
- early detection trials;
- treatment trials to test new therapies in individuals who have cancer;
- quality of life studies;
- studies to evaluate ways of modifying cancer-causing behaviors.

Clinical trials follow strict scientific guidelines that deal with many areas such as:

- study design,
- who can be in the study,
- the kind of information individuals in the study must be given when they decide to participate.

Clinical trials follow protocols for determining:

- the number of members;
- what drugs members will take;
- what medical tests they will have; and
- how often and what information will be collected.

There are four phases of clinical trials. Clinical trials pilot program will include all phases of clinical trials, as long as they meet the criteria defined for the program.

Phase I Trials evaluate how a new drug should be administered and enroll only a small number of patients.
Phase II Trials provide preliminary information about how well a new drug works and generates more information about safety and benefits of the new drug or procedure.
Phase III Trials compare a promising new drug, a combination of drugs or a procedure with the current standard. This phase involves large numbers of people in doctors' offices, clinics and cancer centers. (Many of our members will be in this category). This phase utilizes a randomized process of assigning members to the standard intervention or the trial intervention.
Phase IV Trials continue the evaluation of drugs after FDA approval and utilize drugs already on the market and available for general use.

Coinsurance

A percentage of Eligible Expenses determined after the deductible has been satisfied.

Congenital Anomaly

A physical developmental defect that is present at birth, and is identified within the first twelve months of birth.

Cosmetic Procedures

Procedures or services that change or improve appearance without significantly improving physiological function, as determined by CIGNA on behalf of the SHBP.

Covered Health Service(s)

Those health services provided for the purpose of preventing, diagnosing or treating a Sickness, Injury, Mental Illness, Substance Use Disorder, or their symptoms.

A Covered Health Service is a health care service or supply described in the section titled Covered Expenses, which is not excluded under the section titled General Limitations and Exclusions.

Covered Person

Either the Enrolled Member or an Enrolled Dependent, but this term applies only while the person is enrolled under the Plan. References to "you" and "your" throughout this SPD are references to a Covered Person.

Custodial Services

Any services that are of a sheltering, protective, or safeguarding nature. Such services may include a stay in an institutional setting, at-home care, or nursing services to care for someone because of age or mental or physical condition. This service primarily helps the person in daily living. Custodial care also can provide medical services, given mainly to maintain the person's current state of health. These services cannot be intended to greatly improve a medical condition; they are intended to provide care while the patient cannot care for himself or herself. Custodial Services include but are not limited to:

- Services related to watching or protecting a person;
- Services related to performing or assisting a person in performing any activities of daily living, such as: (a) walking, (b) grooming, (c) bathing, (d) dressing, (e) getting in or out of bed, (f) toileting, (g) eating, (h) preparing foods, or (i) taking medications that can be self administered, and
- Services not required to be performed by trained or skilled medical or paramedical personnel.

DFS1812

Dependent

Dependents are:

- your legally married spouse as defined by Georgia law
- natural, legally adopted children or stepchildren
  - less than 26 years old;
  - 26 years or more and primarily supported by you and incapable of self-sustaining employment by reason of mental or physical handicap. Proof of the child's condition and dependence must be submitted to SHBP within 31 days after the date the child ceases to qualify above. SHBP may, from time to time, require proof of the continuation of such condition and dependence. After that, SHBP may require proof no more than once a year.

Benefits for a Dependent child will continue until the last day of the calendar month in which the limiting age is reached.

DFS57

Designated Facility

A facility that has entered into an agreement with the Claims Administrator or with an organization contracting on behalf of the Plan, to provide Covered Health Services for the treatment of specified diseases or conditions. A Designated Facility may or may not be located within your geographic area.

To be considered a Designated Facility, a facility must meet certain standards of excellence and have a proven track record of treating specified conditions.

Designated Pharmacy

A pharmacy that has entered into an agreement on behalf of the pharmacy with CIGNA or with an organization contracting on its behalf, to provide specific Prescription Drug Products. The fact that a pharmacy is a Network Pharmacy does not mean that it is a Designated Pharmacy, includes Specialty Designated Pharmacy.

Direct Pay

The monthly premium that individuals whom meet the eligibility requirements to continue coverage and pay directly to SHBP (8+ years of service or more). Premiums must be paid directly to DCH, SHBP Division when continuing health insurance after active employment ends.

Durable Medical Equipment

Medical equipment that is all of the following:

- Can withstand repeated use.
- Is not disposable, except urinary catheters and ostomy supplies.
- Is manufactured and used to serve a medical purpose with respect to treatment of a Sickness, Injury or their symptoms.
- Is generally not useful to a person in the absence of a Sickness, Injury or their symptoms.
- Is appropriate for use in the home.

Emergency Services

Emergency services are medical, psychiatric, surgical, Hospital and related health care services and testing, including ambulance service, which are required to treat a sudden, unexpected onset of a bodily Injury or serious Sickness which could reasonably be expected by a prudent layperson to result in serious medical

complications, loss of life or permanent impairment to bodily functions in the absence of immediate medical attention. Examples of emergency situations include uncontrolled bleeding, seizures or loss of consciousness, shortness of breath, chest pains or severe squeezing sensations in the chest, suspected overdose of medication or poisoning, sudden paralysis or slurred speech, burns, cuts and broken bones. The symptoms that led you to believe you needed emergency care, as coded by the provider and recorded by the Hospital on the UB92 claim form, or its successor, or the final diagnosis, whichever reasonably indicated an emergency medical condition, will be the basis for the determination of coverage, provided such symptoms reasonably indicate an emergency.

DFS1533

Employee

The term Employee means a full-time employee of the State of Georgia, the General Assembly or an agency, board, commission, department, county administration or contracted employer that participates in SHBP.

DFS1427M

Employer

The term Employer means the plan sponsor self-insuring the benefits described in this booklet, on whose behalf CIGNA is providing claim administration services.

DFS1595

Enrolled Member

A person who meets all eligibility requirements for the Plan as a result of his or her current or former employment, who is currently enrolled in Coverage and who has paid the necessary contribution or premium for such Coverage in the manner required by the Plan Administrator.

Expense Incurred

An expense is incurred when the service or the supply for which it is incurred is provided.

DFS60

Experimental or Investigational Services

Medical, surgical, diagnostic, psychiatric, substance abuse or other health care services, technologies, supplies, treatments, procedures, drug therapies or devices that, at the time determination is made regarding coverage in a particular case, are determined to be any of the following:

- Not approved by the U.S. Food and Drug Administration (FDA) to be lawfully marketed for the proposed use and not identified in the American Hospital Formulary Service or the United States Pharmacopoeia Dispensing Information as appropriate for the proposed use.
- Subject to review and approval by any institutional review board for the proposed use.
- The subject of an ongoing clinical trial that meets the definition of a Phase 1, 2 or 3 clinical trials set forth in the FDA regulations, regardless of whether the trial is actually subject to FDA oversight.

If you have a life-threatening Sickness or condition (one which is likely to cause death within one year of the request for treatment) we may, in our discretion, determine that an Experimental or Investigational Service meets the definition of a Covered Health Service for that Sickness or condition. For this to take place, we must determine that the procedure or treatment is promising, but unproven, and that the service uses a specific research protocol that meets standards equivalent to those defined by the National Institutes of Health.

Free-Standing Surgical Facility

The term Free-standing Surgical Facility means an institution which meets all of the following requirements:

- it has a medical staff of Physicians, Nurses and licensed anesthesiologists;
- it maintains at least two operating rooms and one recovery room;
- it maintains diagnostic laboratory and x-ray facilities;
- it has equipment for emergency care;
- it has a blood supply;
- it maintains medical records;
- it has agreements with Hospitals for immediate acceptance of patients who need Hospital Confinement on an inpatient basis; and
- it is licensed in accordance with the laws of the appropriate legally authorized agency.

DFS682

Full Retail Cost

Also known as usual and customary charges. This is the amount that a pharmacist would charge a cash-paying customer for a prescription.

Generic

A Prescription Drug Product: (1) that is chemically equivalent to a Brand-name drug; or (2) that CIGNA identifies as a Generic product based on available data resources including, but not limited to, First DataBank, that classify drugs as either brand or generic based on a number of factors. You should know that all products identified as a "generic" by the manufacturer, pharmacy or your Physician may not be classified as a Generic by CIGNA.

HDHP Option

The SHBP option administered by CIGNA and described in this SPD.

Home Health Agency

A program or organization authorized by law to provide health care services in the home.

Hospice Care Program

The term Hospice Care Program means:

- a coordinated, interdisciplinary program to meet the physical, psychological, spiritual and social needs of dying persons and their families;
- a program that provides palliative and supportive medical, nursing and other health services through home or inpatient care during the illness;
- a program for persons who have a Terminal Illness and for the families of those persons.

DFS70

Hospice Care Services

The term Hospice Care Services means any services provided by: (a) a Hospital, (b) a Skilled Nursing Facility or a similar institution, (c) a Home Health Care Agency, (d) a Hospice Facility, or (e) any other licensed facility or agency under a Hospice Care Program.

DFS599

Hospice Facility

The term Hospice Facility means an institution or part of it which:

- primarily provides care for Terminally Ill patients;
- is accredited by the National Hospice Organization;
- meets standards established by CIGNA; and
- fulfills any licensing requirements of the state or locality in which it operates.

DFS72

Hospital

The term Hospital means:

- an institution licensed as a hospital, which: (a) maintains, on the premises, all facilities necessary for medical and surgical treatment; (b) provides such treatment on an inpatient basis, for compensation, under the supervision of Physicians; and (c) provides 24-hour service by Registered Graduate Nurses;
- an institution which qualifies as a hospital, a psychiatric hospital or a tuberculosis hospital, and a provider of services under Medicare, if such institution is accredited as a hospital by the Joint Commission on the Accreditation of Healthcare Organizations; or
- an institution which: (a) specializes in treatment of Mental Health and Substance Abuse or other related illness; and (b) is licensed in accordance with the laws of the appropriate legally authorized agency.

The term Hospital will not include an institution which is primarily a place for rest, a place for the aged, or a nursing home.

DFS1693

Hospital Confinement or Confined in a Hospital

A person will be considered Confined in a Hospital if he is:

- a registered bed patient in a Hospital upon the recommendation of a Physician;
- receiving treatment for Mental Health and Substance Abuse Services in a Partial Hospitalization program;

DFS1815

Initial Enrollment Period

The initial period of time during which Eligible Persons may enroll themselves and their Dependents under the Plan.

Injury

The term Injury means an accidental bodily injury.

DFS147

Inpatient Rehabilitation Facility

A Hospital (or a special unit of a Hospital that is designated as an Inpatient Rehabilitation Facility) that provides rehabilitation health services (physical therapy, occupational therapy and/or speech therapy) on an inpatient basis, as authorized by law.

Inpatient Stay

An uninterrupted confinement, following formal admission to a Hospital, Skilled Nursing Facility or Inpatient Rehabilitation Facility.

Intensive Outpatient Treatment

A structured outpatient Mental Health or Substance Use Disorder treatment program that may be free-standing or Hospital-based and provides services for at least three hours per day, two or more days per week.

Intermediate Care

Mental Health or Substance Use Disorder treatment that encompasses one the following:

- Care at a Residential Treatment Facility.
- Care at a Partial Hospitalization/Day Treatment Program.
- Care through an Intensive Outpatient Treatment Program.

Maintenance Treatment

The term Maintenance Treatment means:

- treatment rendered to keep or maintain the patient's current status.

DFS1650

Maximum Reimbursable Charge - Medical

The Maximum Reimbursable Charge for covered medical services other than Mental Health and Substance Abuse is determined based on the lesser of:

- the provider’s normal charge for a similar service or supply; or
- a policyholder-selected percentage of charges a schedule developed by CIGNA that is based upon a methodology utilized by Medicare to determine the allowable fee for the same or similar service within the geographic market.

The percentage used to determine the Maximum Reimbursable Charge is listed in The Schedule.

In some cases, a Medicare based schedule is not available and the Maximum Reimbursable Charge for covered services is determined based on the lesser of:

1) the provider’s normal charge for a similar service or supply; or
2) the 80th percentile of charges made by providers of such services or supply in the geographic area where it is received as compiled in a database selected by CIGNA.

The Maximum Reimbursable Charge is subject to all other benefit limitations and applicable coding and payment methodologies determined by CIGNA. Additional information about how CIGNA determines the Maximum Reimbursable Charge is available upon request.

GM6000 DFS1997 V5

Medicaid

The term Medicaid means a state program of medical aid for needy persons established under Title XIX of the Social Security Act of 1965 as amended.

DFS192

Medical Necessity

"Medical necessity," "medically necessary care," or "medically necessary and appropriate" means care based upon generally accepted medical practices in light of conditions at the time of treatment which is:

- appropriate and consistent with the diagnosis and the omission of which could adversely affect or fail to improve the patient's condition;
- compatible with the standards of acceptable medical practice in the United States;
- provided in a safe and appropriate setting given the nature of the diagnosis and the severity of the symptoms;
- not provided solely for the convenience of the patient or the convenience of the health care provider or hospital; and
- not primarily custodial care, unless custodial care is a covered service or benefit under this plan.

O.C.G.A. § 33-20A

Medicare

The term Medicare means the program of medical care benefits provided under Title XVIII of the Social Security Act of 1965 as amended.

DFS149

Mental Health Services

Covered Health Services for the diagnosis and treatment of Mental Illnesses. The fact that a condition is listed in the current Diagnostic and Statistical Manual of the American Psychiatric Association does not mean that treatment for the condition is a Covered Health Service.

Mental Health/Substance Use Disorder Designee

The organization or individual, designated by CIGNA, that provides or arranges Mental Health Services and Substance Use Disorder Services for which Benefits are available under the Plan.

Mental Illness

Those mental health or psychiatric diagnostic categories that are listed in the current Diagnostic and Statistical Manual of the American Psychiatric Association, unless those services are specifically excluded under the Plan.

Necessary Services and Supplies

The term Necessary Services and Supplies includes:

- any charges, except charges for Bed and Board, made by a Hospital on its own behalf for medical services and supplies actually used during Hospital Confinement;
- any charges, by whomever made, for licensed ambulance service to or from the nearest Hospital where the needed medical care and treatment can be provided; and
- any charges, by whomever made, for the administration of anesthetics during Hospital Confinement.

The term Necessary Services and Supplies will not include any charges for special nursing fees, dental fees or medical fees.

DFS151

Network Benefits

Benefits for Covered Health Services that are provided by a Network Physician, Network facility or other provider who is a Network Provider with respect to those Covered Services.

Network Pharmacy

A pharmacy that has:

- Entered into an agreement with CIGNA or its designee to provide Prescription Drug Products to Covered Persons.
- Agreed to accept specified reimbursement rates for dispensing Prescription Drug Products.
- Been designated by CIGNA as a Network Pharmacy.

A Network Pharmacy can be either a retail or a mail service or specialty Designated pharmacy.

Network Provider

Also referred to as “participating” when used to describe a provider of health care services, this means a provider that has a participation agreement in effect (either directly or indirectly) with CIGNA or with CIGNA's affiliate to participate in CIGNA's Network; however, this does not include those providers who have agreed to discount their charges for Covered Health Services by way of their participation in the Shared Savings Program. CIGNA's affiliates are those entities affiliated with CIGNA through common ownership or control with CIGNA or with its ultimate corporate parent, including direct and indirect subsidiaries.

A provider may enter into an agreement to provide only certain Covered Health Services, but not all Covered Health Services, or to be a Network provider for only some of CIGNA's products. In this case, the provider will be a Network Provider for the Covered Health Services and products included in the participation agreement, and an Out-of-Network Provider for other Covered Health Services and products. The participation status of providers will change from time to time.

New Presciption Drug Product

A Prescription Drug Product or new dosage form of a previously approved Prescription Drug Product, for the period of time starting on the date the Prescription Drug Product or new dosage form is approved by the FDA, and ending on the earlier of the following date December 31st of the following Plan year.

Nurse

The term Nurse means a Registered Graduate Nurse, a Licensed Practical Nurse or a Licensed Vocational Nurse who has the right to use the abbreviation "R.N.," "L.P.N." or "L.V.N."

DFS155

Open Enrollment Period

A period of time that follows the Initial Enrollment Period during which Eligible Persons who are Active Employees may enroll themselves and Dependents under the Plan, as determined by the DCH, SHBP Division.

Other Health Care Facility

The term Other Health Care Facility means a facility other than a Hospital or hospice facility. Examples of Other Health Care Facilities include, but are not limited to, licensed skilled nursing facilities, rehabilitation Hospitals and subacute facilities.

DFS1686

Other Health Professional

The term Other Health Professional means an individual other than a Physician who is licensed or otherwise authorized under the applicable state law to deliver medical services and supplies. Other Health Professionals include, but are not limited to physical therapists, registered nurses and licensed practical nurses.

DFS1685

Out-of-Network Benefits

Benefits for Covered Health Services that are provided by a Non-Network Physician, Non-Network facility, or a provider that is an Out-of-Network provider with respect to those Covered Health Services.

Out-of-Pocket Maximum

The maximum amount of Annual Deductible and Coinsurance you are required to pay every Plan year. If you use both Network Benefits and Out-of-Network Benefits, two separate Out-of-Pocket Maximums apply. Once you reach the Out-of-Pocket Maximum for Network Benefits, Benefits for those Covered Health Services that apply to the Out-of-Pocket Maximum for Network Benefits are payable at 100% of Eligible Expenses during the rest of that Plan year. Once you reach the Out-of-Pocket Maximum for Out-of-Network Benefits, Benefits for those Covered Health Services that apply to the Out-of-Pocket Maximum for Out-of-Network Benefits are payable at 100% of Eligible Expenses during the rest of that Plan year.

Coinsurance for some Covered Health Services will never apply to the Out-of-Pocket Maximum, as specified in the section titled The Schedule and those Benefits will never be payable at 100% even when the Out-of-Pocket Maximum is reached.

You are solely responsible for paying the following costs, and these costs will never apply to your Deductible or Out-of-Pocket Maximum:

- Any charges for non-Covered Health Services;
- The amount of any reduced Benefits if you don't notify CIGNA
- Charges that exceed Eligible Expenses.

Partial Hospitalization/Day Treatment

A structured ambulatory program that may be a free-standing or Hospital-based program and that provides services for at least 20 hours per week.

Participating Pharmacy

The term Participating Pharmacy means a retail pharmacy with which Connecticut General Life Insurance Company has contracted to provide prescription services to insureds.

DFS1937

Participating Provider

The term Participating Provider means a hospital, a Physician or any other health care practitioner or entity that has a direct or indirect contractual arrangement with CIGNA to provide covered services with regard to a particular plan under which the participant is covered.

DFS1910

Pharmacy

The term Pharmacy means a retail pharmacy.

DFS1934

Pharmacy & Therapeutics (P & T) Committee

A committee of CIGNA Participating Providers, Medical Directors and Pharmacy Directors which regularly reviews Prescription Drugs and Related Supplies for safety and efficacy. The P&T Committee evaluates Prescription Drugs and Related Supplies for potential addition to or deletion from the Prescription Drug List and may also set dosage and/or dispensing limits on Prescription Drugs and Related Supplies.

DFS1919

Physician

The term Physician means a licensed medical practitioner who is practicing within the scope of his license and who is licensed to prescribe and administer drugs or to perform surgery. It will also include any other licensed medical practitioner whose services are required to be covered by law in the locality where the policy is issued if he is:

- operating within the scope of his license; and
- performing a service for which benefits are provided under this plan when performed by a Physician.

DFS164

Plan

The State Health Benefit Plan.

Plan Administrator

Georgia Department of Community Health, SHBP Division.

Plan Sponsor

Georgia Department of Community Health.

Prescription Drug

Prescription Drug means; (a) a drug which has been approved by the Food and Drug Administration for safety and efficacy; (b) certain drugs approved under the Drug Efficacy Study Implementation review; or (c) drugs marketed prior to 1938 and not subject to review, and which can, under federal or state law, be dispensed only pursuant to a Prescription Order.

DFS1708

Prescription Drug Cost

Also known as the contracted rate. The rate we have agreed to pay our Network Pharmacies, including a dispensing fee and any sales tax, for a Prescription Drug Product dispensed at a Network Pharmacy.

Prescription Drug List

Prescription Drug List means a listing of approved Prescription Drugs and Related Supplies. The Prescription Drugs and Related Supplies included in the Prescription Drug List have been approved in accordance with parameters established by the P&T Committee. The Prescription Drug List is regularly reviewed and updated.

DFS1924

Prescription Drug Product

A medication, product or device that has been approved by the Food and Drug Administration and that can, under federal or state law, be dispensed only pursuant to a Prescription. A Prescription Drug Product includes a medication that, due to its characteristics, is appropriate for self-administration or administration by a non-skilled caregiver. For the purpose of Benefits under the Plan, this definition includes:

- Inhalers (with spacers).
- Insulin.
- The following diabetic supplies:

standard insulin syringes with needles;

blood-testing strips - glucose;

urine-testing strips - glucose;

ketone-testing strips and tablets;

lancets and lancet devices;

Glucose monitors.

Prescription Order

Prescription Order means the lawful authorization for a Prescription Drug or Related Supply by a Physician who is duly licensed to make such authorization within the course of such Physician's professional practice or each authorized refill thereof.

DFS1711

Preventive Treatment

The term Preventive Treatment means:

- treatment rendered to prevent disease or its recurrence.

DFS1652

Primary Care Physician

The term Primary Care Physician means a Physician: (a) who qualifies as a Participating Provider in general practice, internal medicine, family practice or pediatrics; and (b) who has been selected by you, as authorized by the Provider Organization, to provide or arrange for medical care for you or any of your insured Dependents.

DFS622

Psychologist

The term Psychologist means a person who is licensed or certified as a clinical psychologist. Where no licensure or certification exists, the term Psychologist means a person who is considered qualified as a clinical psychologist by a recognized psychological association. It will also include any other licensed counseling practitioner whose services are required to be covered by law in the locality where the policy is issued if he is:

- operating within the scope of his license; and
- performing a service for which benefits are provided under this plan when performed by a Psychologist.

DFS170

Qualified Medical Child Support Order (GMCSO)

Any judgment, decree order (including approval of a settlement agreement), or National Medical Support Notice that a court of competent jurisdiction or a state agency issues and is approved by the DCH, SHBP Division as a qualified medical child support order or National Medical Support Notice. The order must provide for medical coverage for your natural child.

Related Supplies

Related Supplies means diabetic supplies (insulin needles and syringes, lancets and glucose test strips), needles and syringes for injectables covered under the pharmacy plan, and spacers for use with oral inhalers.

DFS1710

Residential Treatment Facility

A facility which provides a program of effective Mental Health Services or Substance Use Disorder Services treatment and which meets all of the following requirements:

- It is established and operated in accordance with applicable state law for residential treatment programs.
- It provides a program of treatment under the active participation and direction of a Physician and approved by the Mental Health/Substance Use Disorder Designee.

- It has or maintains a written, specific and detailed treatment program requiring full-time residence and full-time participation by the patient.
- It provides at least the following basic services in a 24-hour per day, structured milieu.

room and board;

evaluation and diagnosis;

counseling; and

referral and orientation to specialized community resources.

A Residential Treatment Facility that qualifies as a Hospital is considered a Hospital.

Retiree and Retiree Coverage

Former employees who have continued SHBP coverage by paying the premiums required for annuitants (currently, the same cost as active premiums) or for former employees with eight or more Years of Service (currently the full cost of coverage) are referred to in this SPD as "retirees." All references to Retiree Coverage apply to coverage in the SHBP as a former employee or annuitant.

Retiree Option Change Period

A period during which former employees enrolled in SHBP coverage may select a new coverage option. A former employee who discontinued SHBP coverage to enroll in TRICARE supplemental coverage may re-enroll in SHBP coverage during the Retiree Option Change Period as long as he or she maintained continuous coverage under either SHBP or TRICARE supplemental coverage.

Review Organization

The term Review Organization refers to an affiliate of CIGNA or another entity to which CIGNA has delegated responsibility for performing utilization review services. The Review Organization is an organization with a staff of clinicians which may include Physicians, Registered Graduate Nurses, licensed mental health and substance abuse professionals, and other trained staff members who perform utilization review services.

DFS1688

Rider

Any attached written description of additional Covered Health Services not described in this SPD. Riders are effective only when signed by SHBP and are subject to all conditions, limitations and exclusions of the Plan except for those that are specifically amended in the Rider.

Semi-private Room

A room with two or more beds. When an Inpatient Stay in a Semi-private Room is a Covered Health Service, the difference in cost between a Semi-private Room and a private room is a Benefit only when a private room is necessary in terms of generally accepted medical practice, or when a Semi-private Room is not available.

Shared Savings Program

The Shared Savings Program provides access to discounts from the provider's charges when covered services are rendered by those non-Network Providers that participate in that program. CIGNA will use the Shared Savings Program to pay claims when doing so will lower Eligible Expenses. CIGNA does not credential the Shared Savings Program providers and the Shared Savings Program providers are non-Network Providers. Accordingly, Benefits for Covered Health Services provided by Shared Savings Program providers will be paid

at the Out-of-Network Benefit level (except in situations when Benefits for Covered Health Services provided by non-Network Providers are payable at Network Benefit levels, as in the case of Emergency Health Services). When CIGNA uses the Shared Savings Program to pay a claim, patient responsibility is limited to Coinsurances calculated on the contracted rate paid to the provider, in addition to any required Annual Deductible.

SHBP

State Health Benefit Plan. The State Health Benefit Plan is comprised of three health insurance plans established by Georgia law: 1) a plan for State employees (O.C.G.A. § 45-18-2), 2) a plan for teachers (O.C.G.A. § 20-2-891), and 3) a plan for non-certificated public school employees (O.C.G.A. § 20-2-911). Currently, benefit options are the same under all three plans and they are usually referred to together as the State Health Benefit Plan. This HDHP Option is an option under the State Health Benefit Plan.

Sickness – For Medical Insurance

The term Sickness means a physical or mental illness. It also includes pregnancy. Expenses incurred for routine Hospital and pediatric care of a newborn child prior to discharge from the Hospital nursery will be considered to be incurred as a result of Sickness.

DFS531

Skilled Nursing Facility

The term Skilled Nursing Facility means a licensed institution (other than a Hospital, as defined) which specializes in:

- physical rehabilitation on an inpatient basis; or
- skilled nursing and medical care on an inpatient basis;

but only if that institution: (a) maintains on the premises all facilities necessary for medical treatment; (b) provides such treatment, for compensation, under the supervision of Physicians; and (c) provides Nurses' services.

DFS193

Specialty Prescription Drug

Prescription Drug Product that is generally high cost, self-injectable biotechnology drug used to treat patients with certain illnesses. Specialty Prescription Drugs include certain drugs for Oncology. You may access a complete list of Specialty Prescription Drugs through the Internet by logging onto **www.myCigna.com** or by calling the number on the back of your ID card.

Spinal Treatment

Detection or correction (by manual or mechanical means) of subluxation(s) in the body to remove nerve interference or its effects. The interference must be the result of, or related to, distortion, misalignment or subluxation of, or in, the vertebral column.

Spinal Treatment Provider

A licensed Chiropractor.

Split Eligibility

When one person or more is under age 65 and one person or more than 65 or older with Medicare Part B. The under 65 individuals are covered by a non-MA option and the 65+ individuals are enrolled in a MA option.

State Extended Coverage

The continuation of health insurance by an individual who will qualify for a retirement annuity but does not qualify for an immediate annuity due to age from a State of Georgia sponsored Retirement Systems.

State Extended Coverage Premium

The monthly premium that individuals who meet the eligibility requirements to continue coverage and pay directly to SHBP (8+ years of service or more). Premiums must be paid directly to DCH, SHBP Division when continuing health insurance after active employment ends prior to receiving an annuity.

State Retirement System

The following are State Retirement Systems:

- Employees' Retirement System (ERS)
- Teachers Retirement System (TRS)
- Public School Employees Retirement System (PSERS)
- Local School System Teachers Retirement Systems
- Fulton County Retirement System (eligible Members)
- Legislative Retirement System
- Superior Court Judges or District Attorney's Retirement System

Substance Use Disorder Services

Covered Health Services for the diagnosis and treatment of alcoholism and substance abuse disorders that are listed in the current Diagnostic and Statistical Manual of the American Psychiatric Association, unless those services are specifically excluded. The fact that a disorder is listed in the Diagnostic and Statistical Manual of the American Psychiatric Association does not mean that treatment of the disorder is a Covered Health Service.

Surviving Dependent

Dependent eligible to continue health insurance in the event of the SHBP member's death.

Terminal Illness

A Terminal Illness will be considered to exist if a person becomes terminally ill with a prognosis of six months or less to live, as diagnosed by a Physician.

DFS197

Transition of Care

Transition of care is a service that enables new enrollees to receive time-limited care for specified medical conditions from an Out-of-Network physician at the benefit level associated with Network physicians.

Transitional Care

Mental Health Services/Substance Use Disorder Services that are provided through transitional living facilities, group homes and supervised apartments that provide 24-hour supervision that are either:

- sober living arrangements such as drug-free housing, alcohol/drug halfway houses. These are transitional, supervised living arrangements that provide stable and safe housing, an alcohol/drug-free environment and support for recovery. A sober living arrangement may be utilized as an adjunct to ambulatory treatment when treatment doesn't offer the intensity and structure needed to assist the Covered Person with recovery.
- Supervised living arrangement which are residences such as transitional living facilities, group homes and supervised apartments that provide members with stable and safe housing and the opportunity to learn how to manage their activities of daily living. Supervised living arrangements may be utilized as an adjunct to treatment when treatment doesn't offer the intensity and structure needed to assist the Covered Person with recovery.

Unproven Services

Services that are not consistent with conclusions of prevailing medical research which demonstrate that the health service has a beneficial effect on health outcomes and that are not based on trials that meet either of the following designs.

- Well-conducted randomized controlled trials. (Two or more treatments are compared to each other, and the patient is not allowed to choose which treatment is received.)
- Well-conducted cohort studies. (Patients who receive study treatment are compared to a group of patients who receive standard therapy. The comparison group must be nearly identical to the study treatment group.)

Decisions about whether to cover new technologies, procedures and treatments will be consistent with conclusions of prevailing medical research, based on well-conducted randomized trials or cohort studies, as described.

If you have a life-threatening Sickness or condition (one that is likely to cause death within one year of the request for treatment) we and CIGNA may, in our discretion, determine that an Unproven Service meets the definition of a Covered Health Service for that Sickness or condition. For this to take place, we and CIGNA must determine that the procedure or treatment is promising, but unproven, and that the service uses a specific research protocol that meets standards equivalent to those defined by the National Institutes of Health.

Urgent Care

Urgent Care is medical, surgical, Hospital or related health care services and testing which are not Emergency Services, but which are determined by CIGNA, in accordance with generally accepted medical standards, to have been necessary to treat a condition requiring prompt medical attention. This does not include care that could have been foreseen before leaving the immediate area where you ordinarily receive and/or were scheduled to receive services. Such care includes, but is not limited to, dialysis, scheduled medical treatments or therapy, or care received after a Physician's recommendation that the insured should not travel due to any medical condition.

Usual and Customary Charge

The amount that a pharmacist would charge a cash-paying customer for a prescription.

Years of Service

Years of Service means years of service credited under the following State Retirement Systems:

- Employees' Retirement System (ERS)
- Teachers Retirement System (TRS)
- Public School Employees Retirement System (PSERS)
- Local School System Teachers Retirement Systems
- Fulton County Retirement System (eligible Members)
- Legislative Retirement System
- Superior Court Judges or District Attorney's Retirement System

Wellness Exams and Immunizations

	Birth to 2 Years	**Ages 3 to 10**	**Ages 11 to 21**	**Ages 22 and older**
Well-baby/Well-child/ Well-person exams (includes height, weight, head circumference, BMI, history, anticipatory guidance, education regarding risk reduction, psychosocial/behavioral assessment)	Birth, 1, 2, 4, 6, 9, 12, 15, 18, 24 & 30 months. Additional visit at 2-4 days for infants discharged less than 48 hours after delivery	Well child exams; once a year	Once a year	Periodic visits, depending on age
Diphtheria, Tetanus Toxoids and Acellular Pertussis (DTaP)	2, 4 & 6 months and 15-18 months	Ages 4 -6	Tetanus, diphtheria, acellular pertussis (Tdap) given once, ages 11-64	Tetanus and diphtheria toxoids booster (Td) every 10 years; Tdap given once, ages 11-64

Haemophilus Influenzae type b conjugate (Hib)	2, 4 & 6 months and 12-15 months			
Hepatitis A (HepA)	12-23 months			May be required for persons at risk
Hepatitis B (HepB)	At birth, 1-4 months and 6-18 months	Ages 3-10 if not previously immunized	Ages 11-18 if not previously immunized	May be required for persons at risk

	Birth to 2 Years	Ages 3 to 10	Ages 11 to 21	Ages 22 and older
Influenza Vaccine		Annually 6 months through 18 years	Ages 19-49, as doctor advises	Ages 19-49, as doctor advises; ages 50 and older, annually
Measles, Mumps and Rubella (MMR)	Ages 12-15 months	Ages 4-6 or 11 & 12 if not given earlier	If not already immune	Rubella for women of childbearing age if not immune
Meningococcal (MCV)			All persons ages 11-18	
Pneumococcal (Pneumonia)	2, 4 & 6 months and 12-15 months			Ages 65 & older, once (or younger than 65 for those with risk factors)
Poliovirus (IPV)	2 & 4 months and 6-18 months	Ages 4-6		
Rotavirus	Ages 6-24 weeks			
Varicella (Chickenpox)	Ages 12-18 months	Ages 4-6	Second dose catch-up or if no evidence of prior immunization or chickenpox	Second dose catch-up or if no evidence of prior immunization or chickenpox
Zoster				Ages 60+

Over-the-Counter Medications

The Patient Protection Affordable Care Act (PPACA), commonly referred to as "health care reform", was signed into law on March 23, 2010. One of the immediate changes of this legislation requires that health plans provide in-network coverage of evidence-based preventive care services at no cost to eligible members. As part of the PPACA's Interim Final Rules for coverage of Preventive Services, CIGNA has determined there are four instances in which the regulations recommend the use of a medication or an over the counter (OTC) medication. SHBP will cover these medications under the pharmacy benefit at no cost to eligible SHBP members.

The following four prescriptions or OTC medications impacted by the regulations will be administered under the SHBP pharmacy benefits received through CIGNA and will require a prescription:

Medication	**Examples**	**Ages**
Aspirin to prevent cardiovascular disease (OTC)	Ascriptin Bufferin Halfprin	Men, ages 45 - 79 Women, ages 55 - 79
Iron Supplementation (OTC) (for children at increased risk for iron-deficiency anemia)	Fer In Sol Vitafol3 ICAR Fer-Gen-Sol	Children, ages 6-12 months
Folic Acid Supplementation (for women planning or capable of pregnancy)	Prenatal Natalcare Optinate Folic Acid	Women of childbearing age
Oral Flouride Supplementation (where water source does not contain fluoride)	Poly Vi Flor Fluor-A-Day Luride Fluritab	Children, ages 6 months to preschool
Note: Ocular topical medication for newborns is also referenced in the regulations; however, this medication is typically administered shortly after birth and covered under the medical benefit.		

CIGNA expects ongoing clarification of the specific requirements of the PPACA legislation, and their policies and coverage standards will evolve accordingly. To get their most current information, you may visit www.informedonreform.com or www.CIGNA.com and click on the "Informed on Reform" link.