



STATE HEALTH BENEFIT PLAN

New Enrollee Decision Guide 2010

PLAN YEAR
January 1–December 31, 2010



GEORGIA DEPARTMENT OF
COMMUNITY HEALTH

Phone Numbers/Contact Information

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

Vendor	Member Services	Web Site
UnitedHealthcare		
HRA	800-396-6515	www.myuhc.com/shbp
HDHP	877-246-4189 TDD 800-255-0056	www.myuhc.com/shbp
CIGNA		
HRA, HDHP	800-633-8519 TDD 800-576-1314	www.mycigna.com/shbp
Pharmacy	Call vendor listed above	
SHBP Eligibility	404-656-6322 800-610-1863	www.dch.georgia.gov/shbp_plans

Notify the Plan of any fraudulent activity regarding Plan members, providers, payment of benefits, etc. Call 1-877-878-3360 or 404-463-7590.

Disclaimer: The material in this booklet is for informational purposes and is not a contract. It is intended only to highlight principal benefits of the medical plans. Every effort has been made to be as accurate as possible; however, should there be a difference between this information and the Plan documents, the Plan documents govern. It is the responsibility of each member, active or retired, to read all Plan materials provided in order to fully understand the provisions of the option chosen. Availability of SHBP options may change based on changes in federal or state law.

The Summary Plan Description (SPD) for each Plan option is posted on the Department of Community Health Web site, www.dch.georgia.gov/shbp_plans. You may print or request a paper copy by calling the Customer Service number on the back of your ID card. Please keep your SPD for future reference. If you are disabled and need this information in an alternative format, call the TDD Relay Service at (800) 255-0056 (text telephone) or (800) 255-0135 (voice) or write the SHBP at P.O. Box 1990, Atlanta, GA 30301.



December 1, 2009

Dear New State Health Benefit Plan Member:

Welcome to the State Health Benefit Plan (SHBP). The SHBP is committed to providing high quality health benefits at an affordable price to its members. Upon joining SHBP, new enrollees have the opportunity to choose between two consumer driven health options each offered by CIGNA Healthcare and UnitedHealthcare (UHC). The High Deductible Health Plan (HDHP) and the Health Reimbursement Arrangement (HRA) offered by CIGNA HealthCare and UHC provide health care consumers with low monthly premiums, extensive provider networks, and 100 percent unlimited coverage for wellness care based on national age and gender guidelines.

If you chose to take advantage of the HRA, you will have the extra benefit of the SHBP contributing dollars to your HRA on an annual basis for treatment of medical expenses. In 2009, this amount is: \$500 for an employee only plan, \$1,000 for an employee plus spouse, \$1,000 for an employee plus child(ren), and \$1,500 for an employee plus spouse and child(ren).

HDHP has the lowest monthly premium and it allows members to start a Health Savings Account (HSA) to set aside tax-free dollars to pay for eligible health care expenses which offsets the higher deductible.

Each plan's design is similar to that of an Open Access Plan (OAP) with in-network and out-of-network benefits, wellness benefits, and other enhanced benefits exclusive to the HRA and HDHP plans.

SHBP offers an annual open enrollment period for all employees. You will be able to select from the consumer driven health options in addition to the options that are offered to active members, which at this time are two OAP and two Health Maintenance Organization (HMO) options during the 2010 open enrollment period. You can access information about these options at www.dch.georgia.gov/shbp.

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

Sincerely,

A handwritten signature in black ink, appearing to read "Rhonda M. Medows".

Rhonda M. Medows, M.D.

Contents

Phone Numbers, Contacts & Provider Information	Inside Front Cover
About the State Health Benefit Plan (SHBP)	Page 3
Eligibility & Qualifying Events	Page 4
General Information and Enrollment	Page 6
SHBP Surcharge Information	Page 8
Understanding Your Plan Options	Page 10
Health & Wellness	Page 13
Benefits Comparison HRA & HDHP	Page 14
Important Notices	Page 18

Common Acronyms

CDHP – Consumer Driven Health Plan

CMS – Centers for Medicare & Medicaid Services

COB – Coordination of Benefits

DCH – Georgia Department of Community Health

FSA – Flexible Spending Account

HDHP – High Deductible Health Plan

HMO – Health Maintenance Organization

HRA – Health Reimbursement Arrangement

HSA – Health Savings Account

IRS – Internal Revenue Service

MAPD PFFS – Medicare Advantage with Prescription Drugs Private Fee-for-Service

OAP – Open Access Plan (Choice Plus-UHC and Open Access Plus-CIGNA)

OE – Open Enrollment

PCP – Primary Care Physician

SHBP – State Health Benefit Plan

SPD – Summary Plan Description

UHC – UnitedHealthcare

State Health Benefit Plan

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

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

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

What can you do to help manage your health care costs?

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

Consider Enrolling in a Flexible Spending Account (FSA) – A FSA (also referred to as a health care spending account) helps you save tax dollars, approximately 26–45 percent depending on your tax situation. By electing to use a FSA, you may set aside up to \$5,040 annually to cover health-related treatments for yourself and your dependents. Eligible expenses include deductibles, co-insurance, over-the-counter items for medical purposes and costs for certain procedures not covered under your health plan. The benefit of this account is that you are able to pay for these out-of-pocket costs with tax-free dollars! Contact your Benefit Coordinator for more information.

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

Steps you can take include:

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

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

Eligibility Information

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

For You

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

- **A full-time employee of the state of Georgia, the Georgia General Assembly, or an agency, board, commission, department, county administration or contracting employer that participates in the SHBP, as long as:**
 - You work at least 30 hours a week consistently, and
 - Your employment is expected to last at least nine months.

Not eligible: Student employees or seasonal, part-time or short-term employees.

- **A certified public school teacher or library employee** who works half-time or more, but not less than 17.5 hours a week

Not eligible: Temporary or emergency employees

- **A non-certified service employee of a local school system** who is eligible to participate in the Teachers Retirement System or its local equivalent. You must also work at least 60 percent of a standard schedule for your position, but not less than 20 hours a week
- **An employee who is eligible to participate in the Public School Employees' Retirement System** as defined by Paragraph 20 of Section 47-4-2 of the Official Code of Georgia, Annotated. You must also work at least 60 percent of a standard schedule for your position, but not less than 15 hours a week
- **A retired employee of one of these listed groups** who was enrolled in the Plan at retirement and is eligible to receive an annuity benefit from a state-sponsored or state-related retirement system. *See the Summary Plan Description (SPD) for more information*
- **An employee in other groups** as defined by law

For Your Dependents

The SHBP covers dependents who meet SHBP guidelines and requires eligibility documentation before SHBP can send dependents' notification of coverage to the health plans.

Eligible dependents are:

- **Your legally married spouse**, as defined by Georgia Law
- **Your never-married dependent children who are:**
 1. **Natural or legally adopted children under age 19**, unless they are eligible for coverage as employees. Children that are legally adopted through the judicial courts become eligible only after they are placed in your physical custody
 2. **Stepchildren under age 19 who live with you** at least 180 days per year and for whom you can provide documentation satisfactory to the Plan that they are your dependents
 3. **Other children under age 19** if they live with you permanently and legally depend on you for financial support – as long as you have a court order, judgment or other satisfactory proof from a court of competent jurisdiction

4. **Your natural children, legally adopted children or stepchildren**, who are physically or mentally disabled prior to reaching age 26 and who depend on you for primary support
5. **Your natural children, legally adopted children or stepchildren or other children** ages 19 through 25 from categories 1, 2, or 3 above who are registered full-time students at accredited secondary schools, colleges, universities or nurse training institutions and, if employed, who are not eligible for a medical benefit plan from their employer. The number of credit hours required for full-time student status is defined by the school in which the child is enrolled.

Documentation Confirming Eligibility for Your Spouse or Dependents

SHBP requires documentation verifying the eligibility of dependents covered under the plan. You must submit the documentation requested by the Plan in order to cover the dependent. No health claims will be paid until the documentation is received and approved by SHBP. However, **do not delay submission of your enrollment form if the required documentation is not readily available as the enrollment form must be submitted to your personnel/benefit coordinator within 31 days of hire or a qualifying event.**

Acceptable documentation:

- **Spouse:** A copy of your certified marriage certificate or a copy of your most recent Federal tax Return (filed jointly with spouse) including legible signatures for you and your spouse with financial information blacked out. Spouse's Social Security number must be on documentation
- **Natural child:** A copy of the certified birth certificate listing the parents by name or a letter of confirmation of birth for newborns. Birth cards without the parents' names are not acceptable. Submit Social Security number upon receipt from Social Security
- **Stepchild:** 1) A copy of the certified birth certificate showing your spouse is the natural parent; 2) A copy of the certified marriage certificate showing the natural parent is your spouse; and 3) A notarized statement that the dependent lives in your home at least 180 days per year. Stepchild's Social Security number must be on the documentation
- **Other children:** 1) A court order, judgment, adoption papers, or other satisfactory proof from a court of competent jurisdiction, or as prescribed by law, and 2) An affidavit that the dependent depends on you for support and lives in your home at least 180 days per year. Submit Social Security number upon receipt from Social Security

For dependents under age two, SHBP will provide coverage without the social security number upon receipt and approval of the above acceptable documentation.

In addition to the above documentation, SHBP requires further documentation to verify the eligibility if the child is age 19 or older.

- **Student:** For students age 19 through 25, a certification letter from the school's registrar. This letter must include: 1) Enrollment date(s) for both current and previous quarters or semesters, 2) Number of credit hours taken each quarter or semester, and 3) Enrollment status (full-time or part-time) for each quarter or semester. Letters of acceptance can be submitted to temporarily extend coverage for students who graduate from high school in May and plan to attend college for the Fall semester or students transferring between colleges
- **Disabled dependent:** Medical documentation of your child's disability must be received and approved by SHBP prior to coverage being granted

Please note:

- The employee's Social Security Number must be written on each document so we can match your dependents to your record. Don't forget to include dependent's Social Security number on their documentation
- Do not send original documents as no documents will be returned to you
- SHBP will allow members to submit verification of their dependent's eligibility any time during the Plan Year; however, no claims will be paid until the documentation is received and approved by SHBP. Coverage will be effective the date of the qualifying event or the first day of the Plan Year, whichever is later

Making Changes When You Have a Qualifying Event

If you experience a qualifying event, you may be able to make changes for yourself and your dependents, **provided you make the request to SHBP within 31 days of the qualifying event.** Also, your requested change must correspond to the qualifying event. For a complete description of qualifying events, see your SPD. You can contact the Eligibility Unit for assistance at 800-610-1863 or in the Atlanta area at 404-656-6322.

Qualifying events include, but are not limited to:

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

General Information and Enrollment

Before You Enroll

You should:

- Read the current *Decision Guide* and SPD to understand your Health Plan Options prior to making your health election
- Contact your employer or payroll location Benefit Coordinator for assistance if you have benefit questions or you may go to www.dch.georgia.gov/shbp
- Read and understand the SHBP Tobacco and Spousal Surcharge Policies, and answer all questions regarding these surcharges. If you fail to answer the questions, the surcharge(s) will apply for the 2010 Plan Year unless you experience a qualifying event
- Gather eligibility verification documents for all dependents for whom coverage has been requested to submit within the required time frame
- Understand the election you make will be valid for the 2010 Plan Year unless you experience a qualifying event
- Additional options may be available to you during the Fall Open Enrollment for coverage effective January 1, 2011

Health Benefit Cost Estimators

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

You can use the PCE to review cost information for prescriptions, anticipated tests and procedures. The information provided by PCE is not meant to be an endorsement of any particular health plan. The service is offered only to help you compare your estimated expenses across each health plan option.

You may access the links to the PCE tools at the DCH Web site, www.dch.georgia.gov/shbp, or by going directly to the vendor Web sites.

How to Enroll

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

- As a new hire, within 31 days of your hire date. If you join the SHBP during that first 31-day enrollment opportunity, your coverage will go into effect on the first day of the month after you complete one full calendar month of employment. See your personnel/payroll office for instructions on how to enroll or if you have benefit questions, you may call the vendor directly at the telephone numbers listed on the inside of the front cover.
- If you decline coverage under SHBP when you first become eligible and later decide to enroll due to a qualifying event or at a future Open Enrollment period, your options will be limited to the HRA and HDHP for your first Plan year of coverage.
- As a result of a qualifying event. *See Making Changes When You Have a Qualifying Event, page 6 of this guide for more details.*

If you decide to become a SHBP member, you will have two major choices to make:

1. Your coverage options:

CIGNA Healthcare

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

UnitedHealthcare

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

**These options allow you to set up a Health Savings Account. See page 12 for more information.*

2. Which eligible dependents would you like to have covered by SHBP? For a list of eligible dependents, refer to pages 4, 5 and 6.

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

3. Which coverage tier? Select the coverage tier you desire for the dependents that you choose to cover. You will be locked into the tier for the 2010 Plan Year unless you experience a qualifying event.

- EE = Employee
- EC = Employee + Child(ren)
- ES = Employee + Spouse
- EF = Employee + Spouse + Child

NOTE: Additional options may be available to you during the Fall Open Enrollment period for coverage effective January 1, 2011.

What Happens if I Have Other Insurance?

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

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

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

COBRA Rights

The Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1986 requires that the Plan offer you, your spouse, or an eligible dependent, the opportunity to continue health coverage if Plan coverage is lost due to a qualifying event. The length of time you, or one of your dependents, may continue the coverage is based on the qualifying event. For further information, please refer to your SPD.

Surcharge Policy

You should be aware that SHBP charges a Tobacco and Spousal Surcharge. A \$60 tobacco surcharge will be added to your monthly premium if you or any of your covered dependents have used tobacco products in the previous 12 months. A \$40 spousal surcharge will be added to your monthly premium if you have elected to cover your spouse and your spouse is eligible for coverage through his/her employment but chose not to take it. If your spouse is eligible for coverage with SHBP through his/her employment, the spousal surcharge will be waived.

You will automatically be charged the applicable surcharges if you fail to answer all questions concerning the surcharges. The surcharges will apply to your premium until the next Plan Year. *See page 9 for ways to have the surcharges removed.*

Please note the SHBP may audit any member covering a spouse who does not pay the spousal surcharge.

Intentional misrepresentation in response to surcharge questions will have significant consequences. You will automatically lose SHBP coverage for 12 months beginning on the date that your false response is discovered.

How to Remove Surcharges

Tobacco

You may have the tobacco surcharge removed if:

- You quit using tobacco products and attend a tobacco cessation program sponsored by the American Cancer Society, the American Lung Association, or other approved programs listed on the DCH Web site, www.dch.georgia.gov/shbp
- You will receive an attendance certification form. You and the representative should both sign this form
- Complete and submit the appropriate Tobacco Affidavit Form and attendance certification form to your payroll location benefit coordinator to complete the required deduction information. The Affidavit Form is available at www.dch.georgia.gov/shbp

Spousal

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

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

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

State Health Benefit Plan Medicare Policy and Retirement

Federal Law requires SHBP to pay primary benefits for active employees and their dependents. Active members or their covered dependents may choose to delay Medicare enrollment. Termination of active employment is a qualifying event for enrolling in Medicare without penalty (except HDHP, see page 21).

If you want to have health insurance under SHBP when you retire, you must enroll for coverage for you and eligible dependents during the OE period prior to your retirement.

Once retired, you will have an annual Retiree Option Change Period that allows you to change your Plan option only. You may add dependents only if you experience a qualifying event and request the change within 31 days and provide the documentation required by SHBP.

For more information, refer to the DCH Web site at www.dch.georgia.gov/shbp.

Understanding Your Plan Options

On the following pages, you will find a brief description of each option and important considerations to help you select the best option for you. To help you understand the information in this section, a few key terms are defined below.

Important Terms to Understand

Allowed Amount – A dollar amount the Plan uses to calculate benefits payable.

Balance Billing – A dollar amount charged by the provider that is over the Plan's allowed amount for the care received. You are subject to balance billing when you receive services from non-participating providers, including emergency services.

Co-insurance Amount – The percentage of the Plan's allowed amount paid by a Plan member. The SHBP generally pays 90 percent to 60 percent of the Plan's allowed amount for covered services, so your co-insurance is between 10 percent and 40 percent.

Covered Services – Services for medically necessary care that are eligible for reimbursement under the Plan.

Deductible – A specified dollar amount, which varies by Plan option, for specified covered services that you must pay out-of-pocket each Plan Year before the option pays a benefit. Depending on your coverage option, the deductible may not apply to some services.

Emergency Care – Care provided when a sudden, severe and unexpected illness or injury happens that could be life threatening or result in permanent impairment of bodily functions if not treated immediately.

Lifetime Maximum – The dollar amount that each Plan member may receive in benefits from the SHBP during his or her lifetime.

Out-of-Pocket Limits – The maximum amount you would have to pay out of your pocket each Plan Year for covered services. Once you meet your out-of-pocket limit for the Plan Year, the Plan pays 100 percent of the allowed amounts for most covered services for the rest of the Plan Year. Your out-of-pocket costs for premiums and non-covered charges are not applied to the limit. The deductible and co-insurance are applied to your annual out-of-pocket limit.

Participating Provider – Any physician, hospital or other health-service professional or facility that offers covered services and that has joined the network of a HRA or HDHP Plan Option. Participating providers may not balance bill Plan members for covered services.

Contact the Member Services unit for each option if you need more detail. Telephone numbers are on the inside front cover. You also may access an SPD online at: www.dch.georgia.gov/sbbp.

Health Reimbursement Arrangement (HRA)

The HRA is a Consumer Driven Health Plan option (CDHP) whose plan design offers you a different approach for managing your health care needs. It is similar to that of the Open Access Plan (OAP) with an in-network and out-of-network benefit, except SHBP funds dollar credits to your HRA each year to provide first dollar coverage for eligible health care and pharmacy expenses. Unused dollars in your HRA account roll over the next Plan year if you are still participating in this option, but will be forfeited if you change options during Open Enrollment or due to a qualifying event.

Plan Features

- The plan offers unlimited wellness benefits based on age and gender national guidelines when seeing in-network providers only
- If you enroll during the year, or change tiers from single to family, your HRA dollar credits will be pro-rated based on the number of months remaining in the Plan Year. The deductible and out-of-pocket maximum are not adjusted
- HRA dollar credits are part of this option only and can only be used with the HRA option
- The amount in your HRA is used to reduce the deductible and maximum out-of-pocket and any unused dollars in your account roll over to the next Plan Year if you are still participating in the Plan
- There is not a separate deductible and out-of-pocket maximum for out-of-network expenses
- After satisfying your deductible, you will pay your co-insurance amount until you reach your out-of-pocket maximum
- Certain drug costs are waived if SHBP is primary and you participate in one of the Disease State Management Programs (DSM) for Diabetes, Asthma and/or Coronary Artery Disease

High Deductible Health Plan (HDHP)

The HDHP design is very similar to that of the OAP with an in-network and out-of-network benefit.

In return for a low monthly premium, you must satisfy a high deductible that applies to all health care expenses except preventive care. **If you have family coverage, you must meet the ENTIRE family deductible before benefits are payable for any family member. You pay co-insurance after you have satisfied the deductible rather than set dollar co-payments for medical expenses and prescription drugs.** Also, you may qualify to start a Health Savings Account (HSA) to set aside tax-free dollars to pay for eligible health care expenses now or in the future. HSAs typically earn interest and may even offer investment options. *See the benefits comparison chart that starts on page 14 to compare benefits under the HDHP to other Plan options.*

Plan Features:

- This option offers 100 percent unlimited wellness benefits based on national age and gender guidelines
- You must satisfy a separate in-network and out-of-network deductible and out-of-pocket maximum
- You pay co-insurance after meeting the entire family deductible for all medical expenses and prescriptions
- This plan is not creditable so if you don't sign up for Medicare when you first become eligible; you may be charged a late enrollment penalty

Health Savings Account (HSA) – For Information Only

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

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

- You can contribute up to \$3,050 single, \$6,150 family as long as you are enrolled in the HDHP. These limits are set by federal law. Unused money in your account carries forward to the next Plan Year and earns interest
- HSA dollars can be used for eligible health care expenses even if you are no longer enrolled in the HDHP or any SHBP coverage
- HSA dollars can be used to pay for health care expenses (medical, dental, vision, over-the-counter medications) that the IRS considers tax-deductible that are **NOT** covered by any health plan (see IRS Publication 502 at www.irs.gov)
- You can contribute an additional \$1,000 if you are 55 or older (see IRS Publication 502 at www.irs.gov)

	HRA	HSA
Overview	A tax-exempt account that reimburses retirees and dependents for qualified medical expenses. Can be funded by employer only.	A tax-exempt custodial account that exclusively pays for qualified medical expenses of the employee and his or her dependents. Can be funded by retiree, employer, or other party.
Who is eligible?	Available to SHBP members enrolled in an HRA. <i>See benefits chart for amounts funded by SHBP.</i>	Available to SHBP members who elect HDHP and may enroll in an HSA of your choice.
Can I have other coverage and take advantage of this benefit?	Yes.	No other general medical insurance coverage permitted. You cannot be enrolled in Medicare Parts A or Part B.
Who owns the money in these accounts?	SHBP. Money reverts back to SHBP upon loss of SHBP HRA coverage.	The member.
Can these dollars be rolled over each year?	Yes.	Yes.
Is there a monthly service charge?	No.	Check with your HSA administrator.
If I terminate my SHBP coverage or change options...	Unused amounts can be distributed until depleted to pay for claims incurred before termination.	Fund disbursement is not tied to individual's employment. Unused amounts can be distributed tax-free for qualified medical expenses. Subject to income and excise tax for non-qualified expenses.

Health & Wellness

Did You Know?

- Cardiovascular disease is the leading cause of death in Georgia
- Diabetes in Georgia is 8% higher than the nation as a whole
- Asthma has been diagnosed in approximately 210,000 children in Georgia between the ages of 0–17 years old
- Certain drug costs are waived for HRA members who participate in the Disease State Management (DSM) Programs for cardiovascular disease, diabetes or asthma

What Can You Do About Your Health?

Take a Personal Health Assessment at least once a year to assist you in learning about potential health risks related to your lifestyle and family history. Each vendor has a health assessment questionnaire available on their Web site that you can complete. After completing the health assessment you will get a customized report that identifies health risks and provides recommendations on ways to help you reduce health risks and suggestions on how to make better lifestyle choices. *Members who complete the health assessment may be contacted by the vendor's registered nurses or health coaches regarding steps they can take to control or eliminate these risks. Participant data is completely confidential and individual results are not shared with your employer or SHBP.*

Utilize the Preventive Health and Wellness Services: One of the best ways to stay healthy is to take advantage of preventive health care. Check with the vendor regarding the plan option you choose to confirm which preventive services are covered. In addition, each vendor offers health coaching and wellness programs such as weight loss, nutrition, and stress management. Contact the vendors to learn more about the programs they offer or visit their Web site to view available services.

Engage in the Health Management Services: Each vendor offers assistance with health care services including disease management, case management and behavioral health. Please contact the vendor of choice for additional details on programs offered such as the DSM Program that waives prescription drug co-payments/costs on certain medications for members who have cardiovascular disease, diabetes and/or asthma and remain compliant with the DSM Program requirements.

Call the Nurse Advice Line: Each vendor has a 24-hour, seven days a week (including holidays) nurse advice line that is available to assist you in making informed decisions about your health. Check with your health plan option for the telephone number.

Good health is priceless. When you live a healthy lifestyle, you can feel better, live easier and save money on health care expenses!

Benefits Comparison

Schedule of Benefits for You and Your Dependents for January 1, 2010 – December 31, 2010

	HIGH DEDUCTIBLE OPTION (HDHP)		HRA OPTION	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Covered Services	<i>The Plan Pays:</i>		<i>The Plan Pays:</i>	
Maximum Lifetime Benefit (combined for all SHBP Options)	\$2 million		\$2 million	
Pre-Existing Conditions (first year in Plan only, subject to HIPAA)	Not applicable		Not applicable	
Lifetime Benefit Limit for Treatment of: (combined for Open Access Option and HDHP) • Temporomandibular joint dysfunction (TMJ)	\$1,100		\$1,100	
Deductibles/Co-Payments: EE = Employee ES = Employee + Spouse EC = Employee + Child(ren) EF = Employee + Spouse + Child(ren) • Hospital deductible per admission	\$1,200 \$2,400 \$2,400 \$2,400	\$2,400 \$4,800 \$4,800 \$4,800	\$1,100* \$1,900* \$1,900* \$2,750*	<i>*HRA credits will reduce this amount.</i> Not applicable
Out-of-Pocket Maximum: EE = Employee ES = Employee + Spouse EC = Employee + Child(ren) EF = Employee + Spouse + Child(ren)	\$1,800 \$3,100 \$3,100 \$3,100	\$4,000 \$7,400 \$7,400 \$7,400	\$2,500* \$4,100* \$4,100* \$5,700*	<i>*HRA credits will reduce this amount.</i>
HRA Credits: EE = Employee ES = Employee + Spouse EC = Employee + Child(ren) EF = Employee + Spouse + Child(ren)	None		\$500 \$1,000 \$1,000 \$1,500	
Physicians' Services				
Primary Care Physician or Specialist Office or Clinic Visits: Treatment of illness or injury	90% coverage; subject to deductible	60% coverage; subject to deductible	85% coverage; subject to deductible	60% coverage; subject to deductible
Primary Care Physician or Specialist Office or Clinic Visits for the Following: • Wellness care/preventive health care • Annual gynecological exams (these services are not subject to the deductible)	100% coverage; not subject to deductible	Not covered; Charges do not apply to deductible or annual out-of-pocket limits	100% coverage; not subject to deductible	Not covered. Charges do not apply to deductible or annual out-of-pocket limits

Dollar amounts, visit limitations, deductibles and out-of-pocket limits are based on a January 1–December 31, 2010 Plan Year. NOTE: Coverage is defined as allowed eligible expenses. Exclusions and limitations vary among Plan options. Contact your specific Plan option for more information.

	HIGH DEDUCTIBLE OPTION (HDHP)		HRA OPTION	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Physicians' Services	<i>The Plan Pays:</i>		<i>The Plan Pays:</i>	
Maternity Care (prenatal, delivery and postpartum)	90% coverage; subject to deductible	60% coverage; subject to deductible	85% coverage; subject to deductible	60% coverage; subject to deductible
Physician Services Furnished in a Hospital <ul style="list-style-type: none"> • Visits; surgery in general, including charges by surgeon, anesthesiologist, pathologist and radiologist 	90% coverage; subject to deductible	60% coverage; subject to deductible	85% coverage; subject to deductible	60% coverage; subject to deductible
Physician Services for Emergency Care Non-emergency use of the emergency room not covered	90% coverage; subject to in-network deductible		85% coverage; subject to deductible	
Outpatient Surgery <ul style="list-style-type: none"> • When billed as office visit 	90% coverage; subject to deductible	60% coverage; subject to deductible	85% coverage; subject to deductible	60% coverage; subject to deductible
----- <ul style="list-style-type: none"> • When billed as outpatient surgery at a facility 	90% coverage; subject to deductible	60% coverage; subject to deductible	85% coverage; subject to deductible	60% coverage; subject to deductible
Allergy Shots and Serum	90% coverage; subject to deductible	60% coverage; subject to deductible	85% coverage; subject to deductible	60% coverage; subject to deductible
Hospital Services				
Inpatient Services <ul style="list-style-type: none"> • Inpatient care, delivery and inpatient short-term acute rehabilitation services 	90% coverage; subject to deductible	60% coverage; subject to deductible	85% coverage; subject to deductible	60% coverage; subject to deductible
----- <ul style="list-style-type: none"> • Well-newborn care 	90% coverage; subject to deductible	60% coverage; subject to deductible	85% coverage; subject to deductible	60% coverage; subject to deductible
Outpatient Surgery—Hospital/facility	90% coverage; subject to deductible	60% coverage; subject to deductible	85% coverage; subject to deductible	60% coverage; subject to deductible
Emergency Care—Hospital <ul style="list-style-type: none"> • Treatment of an emergency medical condition or injury • Non-emergency use of the emergency room not covered 	90% coverage; subject to in-network deductible		85% coverage; subject to deductible	

	HIGH DEDUCTIBLE OPTION (HDHP)		HRA OPTION	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Outpatient Testing, Lab, etc.	<i>The Plan Pays:</i>		<i>The Plan Pays:</i>	
Non Routine Laboratory; X-Rays; Diagnostic Tests; Injections —including medications covered under medical benefits—for the treatment of an illness or injury	90% coverage; subject to deductible	60% coverage; subject to deductible	85% coverage; subject to deductible	60% coverage; subject to deductible
Behavioral Health				
Mental Health and Substance Abuse Inpatient Facility and Partial Day Hospitalization NOTE: Contact vendor regarding prior authorization.	90% coverage; subject to deductible	60% coverage; subject to deductible	85% coverage; subject to deductible	60% coverage; subject to deductible
Mental Health and Substance Abuse Outpatient Visits and Intensive Outpatient NOTE: All services require prior authorization.	90% coverage; subject to deductible	60% coverage; subject to deductible	85% coverage; subject to deductible	60% coverage; subject to deductible
Dental				
Dental and Oral Care NOTE: Coverage for most procedures for the prompt repair of sound natural teeth or tissue for the correction of damage caused by traumatic injury.	90% coverage; subject to deductible	60% coverage; subject to deductible	85% coverage; subject to deductible	60% coverage; subject to deductible
NOTE: Notification required for all UHC options.				
Temporomandibular Joint Syndrome (TMJ) NOTE: Coverage for diagnostic testing and non-surgical treatment up to \$1,100 per person lifetime maximum benefit.	90% coverage; subject to deductible	60% coverage; subject to deductible	85% coverage; subject to deductible	60% coverage; subject to deductible
Vision				
Routine Eye Exam NOTE: Limited to one eye exam every 24 months.	100% coverage; not subject to deductible	Eye exam not covered	100% coverage; not subject to deductible	Eye exam not covered
Other Coverage				
Hearing Services Routine hearing exam	90% coverage for route exam and fitting; subject to deductible. \$1,500 hearing aid allowance every 5 years; not subject to the deductible		85% coverage for routine exam and fitting; subject to deductible. \$1,500 hearing aid allowance every 5 years; not subject to the deductible	
Ambulance Services for Emergency Care NOTE: “Land or air ambulance” to nearest facility to treat the condition.	90% coverage; subject to in-network deductible		85% coverage; subject to deductible	
Urgent Care Services	90% coverage; subject to deductible	60% coverage; subject to deductible	85% coverage; subject to deductible	60% coverage; subject to deductible

	HIGH DEDUCTIBLE OPTION (HDHP)		HRA OPTION	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Other Coverage	<i>The Plan Pays:</i>		<i>The Plan Pays:</i>	
Home Health Care Services NOTE: Prior approval required.	90% coverage; subject to deductible	60% coverage; subject to deductible	85% coverage; subject to deductible	60% coverage; subject to deductible
Skilled Nursing Facility Services NOTE: Prior approval required.	90% coverage up to 120 days per Plan Year; subject to deductible	Not covered	85% coverage; up to 120 days per Plan Year; subject to deductible	Not covered
Hospice Care NOTE: Prior approval required.	90% coverage; subject to deductible	60% coverage; subject to deductible	85% coverage; subject to deductible	60% coverage; subject to deductible
Durable Medical Equipment (DME) —Rental or purchase NOTE: Prior approval required for certain DME.	90% coverage; subject to deductible	60% coverage; subject to deductible	85% coverage; subject to deductible	60% coverage; subject to deductible
Outpatient Acute Short-Term Rehabilitation Services <ul style="list-style-type: none"> • Physical therapy • Speech therapy • Occupational therapy • Other short term rehabilitative services 	90% coverage up to 40 visits per therapy per Plan Year; subject to deductible (not to exceed a total of 40 visits combined, including any out-of-network visits)	60% coverage up to 40 visits per therapy per Plan Year; subject to deductible (not to exceed a total of 40 visits combined, including any in-network visits)	85% coverage; subject to deductible; up to 40 visits per therapy per Plan Year (not to exceed a total of 40 visits combined, including any out-of-network visits)	60% coverage; subject to deductible; up to 40 visits per therapy per Plan Year (not to exceed a total of 40 visits combined, including any in-network visits)
Chiropractic Care NOTE: Coverage for up to a maximum of 20 visits per Plan Year.	90% coverage; subject to deductible	60% coverage; subject to deductible	85% coverage; subject to deductible	60% coverage; subject to deductible
Transplant Services NOTE: Prior approval required.	90% coverage at contracted transplant facility; subject to deductible	Not covered	85% coverage; subject to deductible	60% coverage; subject to deductible
Pharmacy – You Pay				
Pharmacy Co-insurance	20% coverage; subject to deductible; \$10 min.; \$100 max.	Not covered	15% generic; 25% brand; subject to deductible	40% generic; 40% brand; subject to deductible*

*Member must pay full charges at point of sale and submit a paper claim. Members will be reimbursed at the pharmacy network rate less the required co-insurance for covered drugs. Member is responsible for charges that exceed the pharmacy network rate.

About the Following Notices

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

YOUR SHBP OPTION	WHAT HAPPENS IF YOU BUY AN INDIVIDUAL MEDICARE PART D PLAN
SHBP Medicare Advantage Standard or SHBP Medicare Advantage Premium Plan	You will permanently lose SHBP coverage if you purchase a Part D Plan once enrolled in a SHBP Medicare Advantage Plan. You will not pay a Medicare “late enrollment” penalty.
Open Access Plan/HRA HMO	Your Medicare Part D Plan will be primary for your prescription drugs unless you are in the deductible or doughnut hole and then SHBP will provide benefits. If you reach the Out-of-Pocket Limit, SHBP will coordinate benefits with your Medicare Part D Plan. You will not pay a Medicare “late enrollment” penalty.
HDHP (High Deductible)	You will have to pay a Medicare “late enrollment” penalty if you miss the initial enrollment period because the HDHP option is not considered “creditable coverage.”

These notices state that prescription drug coverage under all SHBP coverage options except for the HDHP (High Deductible) option is considered Medicare Part D “creditable coverage.” This means generally that the prescription drug coverage under SHBP MA Standard, SHBP MA Premium, OAP, HMO, and HRA are all “as good or better than” the prescription drug coverage offered through Medicare Part D plans that are sold to individuals.



GEORGIA DEPARTMENT OF
COMMUNITY HEALTH

Two Peachtree Street • Atlanta, GA 30303
(404) 656-6322 • (800) 610-1863

October 1, 2009

About Your Prescription Drug Coverage with CIGNA and UnitedHealthcare OAP, HMO, HRA and Medicare

For Plan Year: January 1–December 31, 2010

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with the State Health Benefit Plan (SHBP) and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and cost of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

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

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

When Can You Join a Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from November 15th through December 31st. However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens to Your Current Coverage if You Do Join a Medicare Drug Plan?

If you decide to join a Medicare drug plan, your SHBP coverage will be affected. You can keep your SHBP coverage if you elect Part D and SHBP will coordinate with Part D coverage the month following receipt of enrollment notice. Your premiums will also be reduced by each Part of Medicare you have. You should send a copy of your Medicare cards to SHBP at P. O. Box 1990, Atlanta, GA 30301.

If you do decide to join a Medicare drug plan and drop your coverage with the State Health Benefit Plan, be aware that you and your dependents can not get this coverage back if you are a retiree.

When Will You Pay a Higher Premium (Penalty) to Join a Medicare Drug Plan?

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

WARNING! Buying any individual Medicare insurance product outside of the Medicare Advantage plans offered through SHBP could **AUTOMATICALLY** and **PERMANENTLY END** your SHBP Coverage.

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

For More Information about this Notice or Your SHBP Current Prescription Drug Coverage...

Contact the SHBP Eligibility Unit at (404) 656-6322 or (800) 610-1863. NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through the State Health Benefit Plan changes. You also may request a copy of this notice at any time.

For More Information about Your Options under Medicare Prescription Drug Coverage...

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

For more information about Medicare prescription drug coverage:

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

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

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

Date: October 1, 2010
Name of Sender: State Health Benefit Plan
Office: Call Center
Address: P. O. Box 1990, Atlanta, GA 30301
Phone Number: (404) 656-6322 or (800) 610-1863



GEORGIA DEPARTMENT OF
COMMUNITY HEALTH

Two Peachtree Street • Atlanta, GA 30303
(404) 656-6322 • (800) 610-1863

October 1, 2009

Important Notice from the SHBP about Your Prescription Drug Coverage and Medicare

About Your Prescription Drug Coverage with the CIGNA and UnitedHealthcare High Deductible Health Plan (HDHP) and Medicare

For Plan Year: January 1–December 31, 2010

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with the State Health Benefit Plan (SHBP) and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

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

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. The SHBP has determined that the prescription drug coverage offered by the HDHP Option, is on average for all plan participants, NOT expected to pay out as much as standard Medicare prescription drug coverage pays. Therefore, your coverage is considered Non-Creditable Coverage. **This is important, because most likely, you will get more help with your drug costs if you join a Medicare drug plan, than if you only have prescription drug coverage from the HDHP offered by SHBP. This is also important because it may mean that you may pay a higher premium (a penalty) if you do not join a Medicare drug plan when you first become eligible.**
3. You can keep your current coverage in a CIGNA or UnitedHealthcare HDHP offered by the SHBP. However, because your coverage is non-creditable, you have decisions to make about Medicare prescription drug coverage that may affect how much you pay for that coverage, depending on if and when you join a drug plan. When you make your decision, you should compare your current coverage, including what drugs are covered, with the coverage and cost of the plans offering Medicare prescription drug coverage in your area. *Read this notice carefully as it explains your options.*

When Will You Pay a Higher Premium (Penalty) to Join a Medicare Drug Plan?

Since the HDHP coverage under SHBP is not creditable, depending on how long you go without creditable prescription drug coverage, you may pay a penalty to join a Medicare drug plan. Starting with the end of the last month that you were first eligible to join a Medicare drug plan but didn't join, if you go 63 continuous days or longer without credible prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without credible coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following November to join.

WARNING! Buying any individual Medicare insurance product outside of the Medicare Advantage plans offered through SHBP could AUTOMATICALLY and PERMANENTLY END your SHBP Coverage.

When Can You Join a Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from November 15th through December 31st. However, if you decide to drop your current coverage under SHBP, since it is an employer sponsored group plan, you will be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan, however you also may pay a higher premium (a penalty) because you did not have Credible Coverage under SHBP.

What Happens to Your Current Coverage if You Decide to Join a Medicare Drug Plan?

If you decide to join a Medicare drug plan, your HDHP coverage under SHBP will be affected. If you enroll in Medicare Part D when you become eligible for Medicare Part D, you can keep your HDHP coverage and the HDHP will coordinate benefits with the Part D coverage. If you do decide to join a Medicare drug plan and drop your HDHP coverage under SHBP, be aware that you and your dependents will not be able to get your SHBP coverage back if you are a retiree.

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

For More Information about this Notice or Your Current Prescription Drug Coverage...

Contact the SHBP Call Center at (404) 656-6322 or (800) 610-1863 for further information. NOTE: You will get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through SHBP changes. You also may request a copy of this notice at any time.

For More Information about Your Options under Medicare Prescription Drug Coverage...

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

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

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

Date: October 1, 2010
 Name of Sender: State Health Benefit Plan
 Office: Call Center
 Address: P. O. Box 1990, Atlanta, GA 30301
 Phone Number: (404) 656-6322 or (800) 610-1863



GEORGIA DEPARTMENT OF
COMMUNITY HEALTH

Rhonda M. Medows, MD, Commissioner *Sonny Perdue, Governor*

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

October 1, 2009

State Health Benefit Plan Annual Legal Notices

Women's Health and Cancer Rights Act

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

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

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

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

Newborns' and Mothers' Health Protection Act

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

Health Insurance and Accountability Act (HIPAA) Annual Notice

This section describes certain rights available to you under the Health Insurance Portability and Accountability Act (HIPAA) when you add a dependent to your State Health Benefit Plan (SHBP) coverage.

The OAP Option contains a pre-existing condition (PEC) limitation. Specifically, the Health Plan will not pay charges that are over \$1,000 for the treatment of any pre-existing condition during the first 12 months of a patient's coverage, unless the patient gives satisfactory documentation that he or she has been free of treatment of medication for that condition for at least six consecutive calendar months. However, a PEC limitation does not apply to converge for:

- Pregnancy; or
- Newborns or children under age 18 who are adopted or placed for adoption, if the child becomes covered within 31 days after birth, adoption or placement for adoption

In certain situations, SHBP members and dependents can reduce the 12-month PEC limitation period. The reduction is possible by using what is called “creditable coverage” to offset a PEC period. Creditable coverage generally includes the health coverage you or a family member had immediately prior to joining the SHBP. Coverage under most group health plans, as well as coverage under individual health policies and governmental health programs, qualifies as creditable coverage.

To reduce the PEC limitation period for your own coverage, you must provide the SHBP with a certificate of creditable coverage from one or more former health plans or insurers that states when your prior coverage started and ended. Any period of prior coverage will reduce the 12-month limitation period if the time between losing coverage and the first day of your SHBP coverage does not exceed 63 days. If you are enrolling as a new hire, the 63-day period is measured from your last day of prior coverage up to your date of hire.

To reduce the PEC limitation period for your dependents (including your spouse), you must provide the SHBP with a certificate of creditable coverage stating when coverage started and ended for each dependent that you want to cover. Any period of prior coverage for that dependent will reduce the 12-month limitation period if no more than 63 days have elapsed between the dependent’s loss of prior coverage and the first day of coverage under the SHBP (or your date of hire, if you are enrolling as a new hire). If you or your dependent (including a spouse) had any break in coverage lasting more than 63 days, you or your dependent will receive creditable coverage only for the period of time after the break ended.

Within two years after your former coverage terminated, you have the right to obtain a certificate of creditable coverage from your employer(s) to offset the pre-existing condition limitation period under the SHBP. The SHBP will evaluate the certificate of creditable coverage or other documentation to determine whether any of the pre-existing condition limitation period will be reduced or eliminated. After completing the evaluation, the SHBP will notify you as to how the pre-existing condition limitation period will be reduced or eliminated. Please submit the certificate of creditable coverage to the Plan with your enrollment paperwork. If you require assistance in obtaining a letter from a former employer, contact your personnel/payroll office.



GEORGIA DEPARTMENT OF
COMMUNITY HEALTH

Two Peachtree Street • Atlanta, GA 30303
(404) 656-6322 • (800) 610-1863

September 15, 2009

To: All Members of the State Health Benefit Plan Who Are Not Enrolled in a Medicare Advantage Option

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

The Department of Health and Human Services considers tobacco use to be a health status-related factor. Therefore, the Department of Community Health will exempt the SHBP from the following requirement in order to apply the tobacco surcharge.

Prohibitions against discriminating against individual participants and beneficiaries based on health status. A group health plan may not discriminate in enrollment rules or in the amount of premiums or contributions it requires an individual to pay based on certain health status-related factors.

The Department of Community Health will exempt the SHBP from the following requirement in order to apply a 31 day period for making any enrollment change as a result of a qualifying event.

Special enrollment periods. Group health plans are required to provide special enrollment periods for individuals who do not enroll in the plan because they have other coverage, but subsequently lose that coverage. Also, if a plan provides dependent coverage, the plan must provide a special enrollment period for new dependents (and the employee if not already enrolled) within 30 days after a marriage, birth, adoption or placement for adoption. A 60-day special enrollment period applies to eligible individuals who lose eligibility for Medicaid coverage or coverage under a State child health plan, or becomes eligible under Medicaid or a State child health plan for group health plan premium assistance.

The exemption from these federal requirements will be in effect for the plan year starting January 1, 2010 and ending December 31, 2010. The election may be renewed for subsequent plan years.

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



GEORGIA DEPARTMENT OF
COMMUNITY HEALTH

Two Peachtree Street • Atlanta, GA 30303
(404) 656-6322 • (800) 610-1863

Revised August 1, 2009.

State Health Benefit Plan Information Privacy Notice

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

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 set premiums and manage costs. 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 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.ga.gov. If you think your privacy rights have been violated, you may file a complaint. You may file the complaint with the Plan and/or the Department of Health and Human Services. You will not get in trouble with the Plan or your employer for filing a complaint.

Address for Complaints:

HBP HIPAA Privacy Unit P.O. Box 1990, Atlanta, Georgia 30301
404-656-6322 (Atlanta) or 800-610-1863 (outside Atlanta)

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

Notify the Plan of any fraudulent activity regarding Plan members, providers, payment of benefits, etc. Call 1-877-878-3360 or 404-463-7590.

Penalties for Misrepresentation

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

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



GEORGIA DEPARTMENT OF
COMMUNITY HEALTH