



# STATE HEALTH BENEFIT PLAN **UPDATER**

GEORGIA DEPARTMENT OF COMMUNITY HEALTH

Spring, 2001

## **Important Notices:**

- **Note on Balance Billing for Standard PPO, PPO Choice and High Option Members:** *When you see out-of-network providers, you are subject to “balance billing.” When an out-of-network provider charges you more than the Plan’s allowed amount for covered services, you are responsible for paying the applicable deductibles, coinsurance, charges for non-covered services, if any, plus the full balance of billed charges that exceed the Plan’s allowed amount. Amounts that are balance billed do not apply toward deductibles or stop-loss limits.*
- *This UPDATER also contains important information about your rights under the **Women’s Health and Cancer Rights Act**. See page 27 for details.*

This *UPDATER* describes important changes to the State Health Benefit Plan (SHBP) for active employees, including information on the new national PPO provider network, an enhanced coverage of preventive care in the High Option, the new prescription drug copayment program, and the closure of selected HMO service areas.

These and other changes contained in this *UPDATER* are significant for all Plan members. You are encouraged to read this entire document to be informed about changes that apply to active employees covered under the SHBP. Plan changes indicated herein are effective July 1, 2001. If you are a retiree, please refer to the Spring 2001 *UPDATER* for retirees.

As you review these changes, it may be helpful to refer to the Glossary of Terms on page 29 for definitions. When a term in the Glossary is used for the first time, all letters in the term are capitalized.

## **PPO Network Enhanced—National Provider Network Effective July 1, 2001**

We are pleased to announce a significant enhancement to the PPO provider network. Effective July 1, 2001, the PPO will have a national network of participating providers through a contract with Beech Street Corporation. Beech Street has a network of over 340,000 physicians and 3,300 acute care facilities with providers in every state. Anyone eligible for State Health Benefit Plan coverage may select a PPO Option and take advantage of the national network of providers.

Many members will benefit from the national network. For example, if...

- you or a dependent lives outside of Georgia, or
- you have a dependent going to school in another state, or
- you are traveling in another state, or
- you want to use an out-of-state provider

and you receive care from a Beech Street provider outside the “Georgia service area,” you will receive the new “in-network/out-of-state” level of benefit coverage (see next page). The Georgia service area includes the state of Georgia and the border communities of the Chattanooga, Tennessee area, including Bradley County; and Phenix City, Alabama. In this *UPDATER*, references to “Georgia” or the “state” include the entire service area.

## Overview of Three Coverage Levels

Benefit coverage under the enhanced PPO Option will be at one of three levels. The terms used to describe the coverage levels are based on whether or not the provider is in the network and then, for in-network coverage, whether or not you receive care in Georgia. The levels of benefit coverage expressed in the table below are percentages of the Plan's ALLOWED AMOUNTS for covered services:

What the Plan Calls Each Level of Benefit Coverage	Level of Benefit Coverage
<b>In-Network/Georgia</b>	<b>90%</b> if you receive care from an in-network MRN/Georgia 1 <sup>st</sup> (Joint Venture) provider located in Georgia.
<b>In-Network/Out-of-State</b>	<b>80%</b> if you receive care from an in-network Beech Street provider located outside of Georgia.
<b>Out-of-Network</b>	<b>60%</b> if you receive non-emergency care from providers who are not participating in either the MRN/Georgia 1 <sup>st</sup> or Beech Street networks, regardless of where you receive care.

## How to Get Provider Information

For the most up-to-date listing of MRN/Georgia 1<sup>st</sup> and Beech Street providers, visit the Internet at [www.healthygeorgia.com](http://www.healthygeorgia.com). Here you will find MRN/Georgia 1<sup>st</sup> providers and a link to Beech Street providers. You may also call Member Services for provider information. (See pages 31-32 for phone numbers.)

Printed provider directories are on file at your personnel/payroll office if you wish to view an MRN/Georgia 1<sup>st</sup> directory. If you live outside of Georgia or are planning an out-of-state trip, you may contact Member Services and request a Beech Street provider directory that lists providers located in the area of your choice. The directory for your requested area will be mailed to your home address.

## Combined Deductibles and Stop-Loss Limits

Except for emergency services, the deductibles and stop-loss limits for in-network/out-of-state (80%) coverage are combined with out-of-network deductibles and stop-loss limits. This means that covered out-of-pocket expenses for in-network/out-of-state services will be applied toward the \$400 individual and \$1,200 family maximum deductibles and to the \$2,000 individual and \$4,000 family maximum stop-loss limits.

For emergency services, covered charges are reimbursed at the 90% in-network/Georgia level and are applied to the in-network/Georgia deductibles (\$300/\$900) and stop-loss limits (\$1,000/\$2,000)—regardless of the provider's network status or where you receive emergency services. However, you are subject to BALANCE BILLING if services are from out-of-network providers. If you use a network provider, you are protected from balance billing and you do not have to pay at the time you receive services or submit claim forms.

If you or anyone with you is able, call the NurseCall 24 program at 800-524-7130, which is available 24 hours per day, 7 days per week, for information on the nearest MRN/Georgia 1<sup>st</sup> and Beech Street providers. If you receive a referral to the emergency room (E/R) after your call is complete, the E/R copayment is reduced to \$40 (from \$60).

## Coverage Level Issues

- **If you receive care in Georgia, you must use an MRN/Georgia 1<sup>st</sup> provider to receive the 90% level of benefit coverage, unless you require emergency care as defined by the Plan.** If you select a Beech Street provider inside the Georgia service area, your level of benefit coverage is the out-of-network (60%) level and you are subject to balance billing. Beech Street providers located in Georgia are considered out-of-network because Beech Street does not have a contract with the Health Plan to provide network services in Georgia.
- Members and dependents living, working, or going to school outside of Georgia may travel into the state and select an MRN/Georgia 1<sup>st</sup> provider to receive the 90% level of in-network/Georgia coverage.
- Charges from out-of-network HOSPITAL-BASED PHYSICIANS are subject to balance billing, including charges for services performed within an in-network hospital. However, if you use an in-network/out-of-state hospital and receive services from an out-of-network hospital-based physician, your level of

benefit coverage is 80% of the network rate (rather than 60%) and charges are subject to balance billing.

- There is no international network of participating providers in the PPO Options. All non-emergency services received outside the United States are reimbursed at 60% of the OUT-OF-NETWORK RATE and are subject to balance billing, with reimbursements based on the Plan's allowed amounts for covered services and on currency exchange rates.

## How to Maximize Your Coverage

- The Beech Street network used for SHBP members does not include providers in the Georgia service area, mental health/substance abuse providers, or transplant providers. The SHBP has an existing national network of mental health/substance abuse providers in the Behavioral Health Services (BHS) Program and a national network of contracted transplant centers. Be sure to utilize these existing networks to maximize your coverage.
- Members are responsible for verifying the network status of their provider before receiving services—for both the MRN/Georgia 1<sup>st</sup> and Beech Street networks. You may verify the provider's network status when you call to make an appointment.
- Members are responsible for precertifying inpatient stays and specified outpatient tests and procedures—even if the provider participates in the Beech Street network. See page 27 for the most current list of outpatient tests and procedures that require precertification through the Medical Certification Program (MCP).
- When you receive your new SHBP ID card in June, you will notice that a series of new logos is on your card. The logos include the Beech Street logo and a number of affiliated provider networks in different states. When you receive care, you must present your ID card to the provider, including providers you see outside of Georgia. Information on your card will assist providers in filing your claim correctly and charging you the correct amount. Failure to present your SHBP ID card to your provider could result in balance billing.

See pages 12-24 for a detailed schedule of benefits that compares the enhanced Standard PPO Option to the High Option. If you are eligible for HMO coverage, request a *Health Plan Decision Guide* package from your personnel/payroll office.

## Recap of New Pharmacy Benefit Manager

The last issue of *UPDATER* included an article about the new pharmacy benefit manager and the transition from PAID Prescriptions to Express Scripts. Refer to the January 1, 2001 *UPDATER* for details on the new pharmacy benefit manager and services provided. This *UPDATER* recaps key points about Express Scripts, and offers more detail on the new prescription drug program in the following section.

## New Pharmacy Benefit Manager—Express Scripts

- Effective January 1, 2001, the SHBP changed from PAID Prescriptions to Express Scripts to manage the pharmacy benefits offered to Standard PPO, PPO Choice, and High Option members. Express Scripts contracts with drug manufacturers for the best prices available, manages the Plan's network of retail pharmacies, processes prescription drug claims, and answers questions related to prescription drugs.
- Visit the Department of Community Health's Web site at [www.dch.state.ga.us](http://www.dch.state.ga.us) to view the list of participating Express Scripts pharmacies and the *Georgia Department of Community Health PREFERRED DRUG LIST*. (See more about the preferred drug list in the next section.) Once you arrive at the home page, click onto "Public Employees" and then once you are on the Division of Public Employee Health Benefits home page, you can click on the appropriate icon to view the list of participating pharmacies or the preferred drug list.
- Any licensed pharmacy may join the Express Scripts network, provided the pharmacy agrees to the terms and conditions of being in the network. If your pharmacy is not part of the network, ask your pharmacist to call Express Scripts at 877-650-9340. (This number is reserved for pharmacists.)

## Two Member Service Units

- Starting July 1, 2001, Blue Cross and Blue Shield (BCBS) will discontinue prescription drug claim processing. Call the SHBP Member Service Unit at BCBS only if you have hospital, medical, or other non-prescription drug claim questions. All questions regarding prescription drug coverage, copayments, and paper claims should be directed to Express Scripts. Note: For drug purchases made prior to July 1, 2001, BCBS will process those claims through September 28, 2001. If the drug claim is received after September 28, 2001, and the claim is for a drug purchased prior to July 1, 2001, the Plan will deny the claim.
- Starting July 1, 2001, a dedicated Express Scripts Member Service Unit will be available 24 hours per day, 7 days per week to answer all questions about your prescriptions, including questions about the drugs you are taking, network pharmacy locations, drug copayments, and claim questions. Call Express Scripts toll-free at 877-650-9342. The number will be listed on the back of your SHBP identification card.

## New Prescription Drug Program

The Department of Community Health (DCH) understands your concerns about the current drug benefit, which requires that members meet the Plan's deductible first, pay in *full* for prescription drugs at the point of purchase, file a claim form, and then wait for reimbursement on expensive prescriptions.

When the new prescription drug program takes effect on July 1, 2001, members will:

- only pay a copayment for covered drugs, not the full cost up-front,
- have no deductible to pay,
- have no claims to file, and
- have no waiting for reimbursement when members use an Express Scripts network pharmacy.

The Health Plan implemented the new program for a number of other reasons as well:

- to help keep employee premiums more affordable;
- to make high quality and cost-effective drugs available to members;
- to manage prescription drug spending in a medically-appropriate manner and help members avoid unhealthy drug interactions;

- to maintain the freedom SHBP members have to select any covered drug; and
- to address anticipated increases in drug costs.

As we reported in the last issue of the *UPDATER*, prescription drug spending in the U.S. is expected to increase from 15% to 18% per year over the next five years. In the SHBP, prescription drug costs have increased 20% per year over the last two years alone. Health plans across the country are experiencing dramatic cost increases and are making changes—or have already made changes—to their prescription drug programs. Although moving to a new prescription drug program with copayments is a significant change for the SHBP, most major employers' health plans have included prescription drug copayments for years.

When the new prescription drug benefit becomes effective July 1, you will be able to fill your prescriptions with a copayment rather than paying the full cost at the point of sale. Each time you fill your prescription, you'll generally pay between \$10 and 20% of the network drug cost, depending upon your personal preferences and medical needs. The next section provides you with detailed information.

## How the New Prescription Drug Program Works

### Overview

The program includes a three-level or "three-tier" copayment for covered drugs, with the first tier for GENERIC DRUGS, the second tier for PREFERRED BRAND NAME DRUGS, and the third tier for NON-PREFERRED BRAND NAME DRUGS—as described in the table below:

Tier	Type of Drug	Copayment Amount Per Prescription (up to a 30-day supply) <sup>1</sup>
First Tier	Generic	\$10.00
Second Tier	Preferred Brand	\$20.00
Third Tier	Non-Preferred Brand <sup>2</sup>	20% of network price (\$35.00 minimum/ \$75.00 maximum)

<sup>1</sup>See page 5 for footnotes.

If the drug's USUAL AND CUSTOMARY (U&C) COST is less than the copayment, the member does not pay the regular copayment, just the lesser U&C amount.

<sup>1</sup>Copayments are based on supplies of up to 30 days; some drugs are limited to a standard other than 30-day supplies (see page 6). For drugs the SHBP defines as MAINTENANCE DRUGS, you may obtain up to a 90-day supply for your prescription(s) with one copayment per 30-day supply. Copayments for preferred and non-preferred brand name drugs may be higher if a generic alternative drug is available and your physician does not require that you take the preferred or non-preferred brand name drug. See

examples starting on page 8. You do not have to pay the general deductible before you have coverage for prescription drugs.

<sup>2</sup>All non-preferred drugs have a generic or preferred brand alternative. Use of an alternative generic or preferred brand name drug can save you money. Preferred drug alternatives are CHEMICALLY EQUIVALENT while more cost effective. If you are taking a non-preferred drug and your physician agrees, you may want to give an alternative a "try." If you try a preferred drug alternative and are not satisfied, you can always switch back to your original prescription.

## How the New Prescription Drug Benefit Program Compares to the Old Program

The information contained in the table below should answer basic questions about how the new prescription drug program works and how coverage compares with the old prescription drug program.

Benefits	How the New Prescription Drug Program Works Effective July 1, 2001	How the Prescription Drug Program Worked Prior to July 1, 2001
<b><i>What's the advantage to me?</i></b>	If you use an Express Scripts network pharmacy, you will be able to fill your prescriptions with a copayment rather than paying the full cost at the point of sale. You won't have to pay a deductible up front and wait for reimbursement from the Plan before receiving a prescription drug benefit.	You were required to meet your deductible, pay the full cost, and wait for reimbursement. You received reimbursement of 90% of the network rate.
<b><i>Do I need a separate prescription drug card?</i></b>	No. You will receive a new SHBP ID card in June. It will have the Express Scripts logo on it (as well as other new logos) with important drug program information, including copayment amounts. Be sure to present your new ID card to pharmacists starting on July 1, 2001, so that your claim gets filed correctly and that you pay the correct amount.	There was no prescription drug card.
<b><i>Are my out-of-pocket expenses applied to deductibles and stop-loss limits?</i></b>	Your copayments do not apply toward your deductible or out-of-pocket (stop-loss) limits. You do not have to meet a deductible before receiving prescription drug coverage.	Out-of-pocket expenses were applied to the deductibles and stop-loss limits.
<b><i>What if the Usual &amp; Customary (U&amp;C) cost of the medication is less than the copayment?</i></b>	If the U&C cost of your medication is less than the copayment amount, you only pay the U&C cost of the drug (the lesser amount).	Not Applicable.

<b>Benefits</b>	<b>How the New Prescription Drug Program Works Effective July 1, 2001</b>	<b>How the Prescription Drug Program Worked Prior to July 1, 2001</b>
<b><i>What if I prefer the brand name drug to the generic?</i></b>	When a member chooses to purchase a preferred brand name or non-preferred brand name drug rather than its generic equivalent, the member will be responsible to "PAY-THE-DIFFERENCE" between the two in addition to the generic copayment. Amounts paid toward the difference are not limited by the Plan. It is possible, for example, that you would pay over the \$75 copayment amount for non-preferred brand name drugs. (See the example on page 9.)	The Plan also required you to pay additional amounts.
<b><i>What if the doctor requires the brand name drug?</i></b>	If the treating physician mandates the preferred brand name or non-preferred brand over the generic, the "pay-the-difference" requirement will not apply. The member will be responsible for only the brand name or non-preferred brand name copayment.	The Plan also waived payment of additional amounts.
<b><i>Are there any supply limitations?</i></b>	Generally, most medications have specific quantity level limits that have been approved for a 30-day supply. In some instances, the approved quantity level limit is based on a standard other than daily dosages. SHBP quantity level limits reflect the adoption of the recommendations proposed by pharmaceutical manufacturers and clinical/medical experts. Supply limits for drugs defined as maintenance drugs are described on page 7.	Supplies were limited to 100 units of a medication, or a 90-day supply—if it was more than 100 units.
<b><i>What are some common examples of drugs with quantities limited to a standard other than 30-day supplies?</i></b>	Some drugs have quantity level limits (QLLs) based on fixed monthly standards such as the number of kits, vials, packages, rolls, patches, lozenges, syringes, etc. Prescriptions for a number of inhalers have quantity level limits that vary by prescription and strength. Commonly used drugs with QLLs include: Ambien, Sonata,Viagra, Flovent, Imitrex, Toradol, Diflucan 150mg., and Zithromax. Contact Express Scripts at 877-650-9342 for the standard prescription amounts on these and other drugs with special quantity level limits.	The Plan also had specific drugs with quantity limitations based on a standard other than 30-day supplies.

**Benefits****How the New Prescription Drug Program Works Effective July 1, 2001****How the Prescription Drug Program Worked Prior to July 1, 2001*****What if I take medication defined as a maintenance drug?***

You may obtain up to a 90-day supply for your initial prescription and for each refill (if written for 90 days) with one copayment per 30-day supply for drugs listed as maintenance drugs under the Plan.

Whatever the cost of your maintenance prescription, you paid the full cost at the point of sale for the initial prescription and for refills, and then waited for reimbursement of 90% after the general deductible had been met.

***What if I purchase a drug from a pharmacy that is not in the Express Scripts Pharmacy Network?***

If you do not use an Express Scripts network pharmacy, you must submit a paper claim with a pharmacy receipt and will be reimbursed at the pharmacy network rate less the required copayment for covered drugs (with the same in-network limitations and restrictions.) You are subject to balance billing. Remember: If your pharmacy is not already in the Express Scripts network, any licensed pharmacy may join if it agrees to the terms of being in the network.

If you used a non-network pharmacy and were charged more than the network rate, you were responsible for the 10% coinsurance amount, plus the amount charged over the network rate.

***Will I receive any more printed information on the new prescription drug program?***

Yes. You should receive a member handbook in July, which includes information on: benefit coverage; how to use the new benefit; network pharmacy locations near your home; and the preferred drug list.

Not applicable.

## Other Important Details about the New Prescription Drug Program

- If you have primary coverage from another health plan, prescription drug benefits provided by the 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. To request a secondary payment from Express Scripts, you will need to send a paper claim and attach a copy of the Explanation of Benefits (EOB) form from the primary plan. Secondary payments are subject to network allowed amounts for covered drugs and the applicable copayment will be deducted from the secondary payment, if any. Please contact Express Scripts for more details.
- If you have coverage under two SHBP contracts (cross coverage), prescription drug benefits provided by the SHBP will not be coordinated. A copayment will be required for each filled prescription. However, you may present either your primary or secondary SHBP ID card at the pharmacy.

- Some prescription drugs require medical authorization before you can receive Plan coverage for the drug. The special approval is called a “PRIOR AUTHORIZATION” or “PA” and may be done while you are at the pharmacy, any time of day or day of the week. Only your pharmacist or physician may obtain the authorization on your behalf by contacting Express Scripts. Some drugs that require prior authorization include:

Adderall (for patients 21 and over)	Dexedrine	Muse
Caverject	Dextrostat	Panretin gel
Cerezyme	Differin (for patients 30 and over)	Procrit
Crinone 8%	Diffucan (except 150mg.)	Prolastin
Desmopressin acetate (intranasal solution)	Edex	Retin A (for patients 30 and over)
Desoxyn	Epogen	Sporonox
	Lamisil	Viagra

(continued from page 7)

If you take one of the drugs described on page 7, see your physician at your earliest convenience after June 30, 2001, so that your physician may request a prior authorization of your prescription. Seeing your physician ahead of time will save you time at the pharmacy when you fill your prescription on or after July 1, 2001. Contact Express Scripts at 877-650-9342 for information on these and other drugs that require prior authorization.

- Effective July 1, 2001, the Plan will not require members to obtain and submit Letters of Medical Necessity (LOMNs) for specified prescription drugs. On and after July 1, 2001, if you are filling a prescription that requires prior authorization through Express Scripts, but you already have a valid authorization for the drug, you will not be required to pre-authorize your drug again. However, if you need to fill the prescription after the date your authorization expires, your pharmacist or physician will need to contact Express Scripts to receive prior authorization for the prescription.
- Some drugs are not covered under the new pharmacy benefit, including Tamiflu, Relenza, medications for cosmetic reasons (such as Renova and Vaniga), and appetite suppressants and other weight-loss drugs (such as Xenical). Your physician may prescribe medications that are not covered under the SHBP pharmacy benefit. If that happens, you will be responsible for the full cost of the non-covered drugs. Also, the Plan does not cover mail-order prescriptions. Please refer to the State Health Benefit Plan booklet and subsequent *UPDATERS* for a list of complete drug exclusions.
- You and your physician have choices. Discuss the options and select the prescription drug that works for you and is affordable. If you or your physician has questions, call Express Scripts before you leave your physician's office.
- For prescription medications purchased on or after July 1, 2001, member appeals and inquiries regarding prescription drug coverage may be mailed to: **Express Scripts, 6625 West 78<sup>th</sup> Street, Georgia Department of Community Health - SHBP, BL0340, Bloomington, MN 55439-0842.**

## Prescription Drug Copayment Examples

The three-tier prescription drug program sets the lowest copayment for generics, the middle-level copayment for preferred brand name drugs, and the highest copayment for non-preferred brand name drugs. Here are some examples of how your prescription drug copayment program will work for covered drugs:

Generic Drugs	Cost/Copayment
If the cost is	\$18.23
You pay the copayment	\$10.00
The Plan pays the difference	\$ 8.23
If the usual and customary cost is \$7.49, you pay	\$ 7.49

**Preferred Brand Name Drugs**  
(when no generic drug alternative is available or your physician requires that you take the brand name drug)

	Cost/Copayment
<b>EXAMPLE A</b>	
If the cost is	\$45.22
You pay the copayment	\$20.00
The Plan pays the difference	\$25.22
If the usual and customary cost is \$18.23, you pay	\$18.23

<b>EXAMPLE B</b>	
If the cost is	\$130.50
You pay the copayment	\$ 20.00
The Plan pays the difference	\$110.50

### Preferred Brand Name Drugs

(when there is a generic alternative available and your physician does not require that you take the brand name drug)

#### Cost/Copayment

If the brand name drug cost is	\$45.22
And the generic drug cost is	\$18.23
You pay the cost difference	\$26.99
Plus the generic copayment	\$10.00
You pay a total of	\$36.99
The Plan pays	\$ 8.23

### Non-Preferred Brand Name Drugs

(when there is no generic alternative available or when your physician requires that you take the non-preferred brand name drug.)

#### Cost/Copayment

#### If the usual and customary cost is...

under \$35, you pay...	under \$35 (the usual and customary cost charged by the pharmacy where you fill your prescription).
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#### If the network cost is...

over \$35 but no more than \$175, you pay...	\$35.00 (the non-preferred minimum copayment).
over \$175 but no more than \$375, you pay...	\$35 to \$75, depending on the network price (copayment equals 20% of the network drug cost).
over \$375, you pay...	\$75.00 (the non-preferred maximum copayment).

### Non-Preferred Brand Name Drugs

(when there is a generic alternative available and your physician does not require that you take the non-preferred brand name drug)

#### Cost/Copayment

If the brand name drug cost is	\$185.41
And the generic drug cost is	\$ 53.74
You pay the cost difference	\$131.67
Plus the generic copayment	\$ 10.00
You pay a total of	\$141.67
The Plan pays	\$ 43.74

### Notes on Non-Preferred Drugs

A non-preferred brand name drug always has an alternative in the new drug benefit program.

- Use of an alternative preferred brand name drug or generic drug can save you money.
- Preferred drug alternatives (generic or preferred brand name) are chemically equivalent while more cost effective.
- If you are taking a non-preferred drug and your physician agrees, you may want to give an alternative a “try.” If you try a preferred drug alternative and are not satisfied, you can always switch back to your original prescription.

## Diabetic and Ostomy Supplies

### Effective July 1, 2001:

Diabetic supplies purchased at an Express Scripts pharmacy will have a \$10 copayment. If the usual and customary cost of the supply is less than \$10, you only pay the usual and customary cost. You do not have to meet a deductible first or file any claims. If you purchase supplies at a pharmacy, you must submit your claim through Express Scripts to have coverage under the Plan.

If you decide not to purchase diabetic supplies at a pharmacy, you may file a medical claim with the Health Plan, using an Employee Health Expense Report (EHER) form and a receipt from the supplier. If you file a medical claim, you will receive reimbursement for covered supplies, subject to the applicable deductible and coinsurance amounts. Covered diabetic supplies include insulin syringes with needles, blood and urine testing strips for glucose, ketone testing strips and tablets, lancets and lancet devices, glucose/ketone combination strips, alcohol swabs, novopen, and blood glucose testing monitors.

Ostomy supplies will continue to be paid as a medical benefit regardless of where you purchase the supplies. File a medical claim using an EHER form and include a receipt from the supplier.

**Note:** Some supplies may have quantity level limits. Diabetic and ostomy supplies require a prescription from your physician to be covered under the Plan.

## Members in Plan-Approved Disease State Management Programs

Effective July 1, 2001, if you are a participant in one of the Plan's disease state management programs for diabetes, congestive heart failure, or asthma, your prescription drug copayments may be waived for the drug(s) related to your respective disease. Certain restrictions apply to the copayment waiver. If you would like more information on the new policy or on the Plan's disease state management programs, contact the Medical Certification Program (MCP) at 800-858-4626, Ext. 4661.

## Self-Administered Injectable Medications

Currently, the Plan considers most injectable medications as prescription drugs, which may be purchased at a pharmacy and submitted as a prescription drug claim. Effective July 1, 2001, most injectable medications will be considered a medical benefit, subject to coinsurance and the Plan's general deductible.

On and after July 1, 2001, members may need to visit their physician's office for an injection if their injectable medication is covered as a medical benefit and not as a prescription drug. Based on reviews conducted by Express Scripts clinicians, Express Scripts has determined that a limited number of injectable medications are appropriate for self-administration and that the majority of injectable medications are appropriately administered in a physician's office.

If you take a self-injectable medication such as Caverject, Betaseron, or Intron A, please contact Express Scripts to discuss how the Health Plan will cover your medication on and after July 1, 2001—and whether or not your physician will need to administer the injection.

**Note:** Insulin is and will remain a prescription drug benefit and a drug that is considered appropriate for self-administration.

## Preferred Drug List

The Preferred Drug List will be posted on the DCH Web site at [www.dch.state.ga.us](http://www.dch.state.ga.us). When you arrive, click onto "Public Employees." When you arrive at the Division of Public Employee Health Benefits home page, click onto the appropriate icon. If you do not have Internet access, please contact Express Scripts at 877-650-9342 to discuss drugs on the list or obtain information on the preferred status of a drug. In July, members should receive an Express Scripts member handbook that includes an abbreviated list of the most commonly used preferred drugs. Participating physicians also will receive the preferred drug list so that you and your doctor can work together to maximize your prescription drug benefits.

Note: The *Georgia Department of Community Health Preferred Drug List* is subject to change. The list will be updated as new drugs are approved by the FDA and as generic drugs are introduced that are alternatives to preferred brand name drugs. (When a generic drug replaces a preferred brand name drug, the preferred brand name drug automatically becomes a non-preferred brand name drug.) Just prior to July 1, 2001, we recommend that you double check the status of your prescriptions as changes may have occurred since you made your initial inquiry.

## A Reminder About Your Health Care Spending Account

If you participate in a Health Care Spending Account offered through your employer, you may want to consider changing your contribution rate to account for the new prescription drug copayments.

If you participate in the Health Care Spending Account offered through the Georgia Merit System, please take note of the following: The Georgia Merit System is increasing the maximum contribution rate for the 2001-2002 Health Care Spending Account to \$5,040 (from \$3,000). This account allows you to set aside pre-tax dollars from your paycheck to cover “excess” health care expenses not reimbursed by your health plan(s) for you and your dependents, including prescription drug copayments. Depending on your tax situation, this can mean a tax savings of 26% to 45%. To calculate your optimal HCSA contribution and determine your potential tax savings, please visit SHPS.NET Online Services at [www.shps.net](http://www.shps.net). For further information about the Spending Accounts Program, call 800-893-0763 and press the star (\*) key to speak with a benefits counselor.

### Important Notes

- If you are an SHBP member working for a school system that offers you a health care spending account benefit, please see your school system’s benefit representative for more information.
- Effective July 1, 2001, the Plan will not issue Explanation of Benefit (EOB) forms to members following a prescription drug purchase. In lieu of an EOB form, you may submit a copy of the pharmacy receipt with the appropriate Health Care Spending Account form(s) to apply for a reimbursement of your prescription drug copayments.

## Benefit Enhancements and Notices

### Standard PPO and PPO Choice Options

Effective July 1, 2001, the Plan will expand the list of covered lab work and diagnostic tests provided under the wellness benefit. Wellness services are covered up to \$500 per person per Plan Year.

### PPO Choice Option

PPO Choice members are not required to renominate providers at the beginning of each new Plan Year. Please disregard the notice in the Spring 2000 *UPDATER* regarding renomination requirements. The in-network relationship between the nominated provider and the patient has no time limit and remains in effect until either the provider or patient terminates the relationship.

If you are changing options to PPO Choice, contact Member Services on or after July 1, 2001, to request a provider nomination package. If the provider agrees to the PPO’s terms and conditions, both you and the nomi-

nated provider must complete the nomination form. You should mail the completed form to the address indicated. MRN/Georgia 1<sup>st</sup> will send out an acceptance or rejection notice within three business days of receiving your completed nomination form. Covered services are not reimbursed at the in-network level of benefit coverage until after the PPO approves the nomination.

If you are a current PPO Choice Option member or you are considering PPO Choice, please note that you may only nominate providers located and licensed in Georgia—even if you live out-of-state.

### High Option

We are pleased to announce the following High Option benefit improvements effective July 1, 2001:

- Physician fees for preventive care office visits will be covered at 90% of the HIGH OPTION (H/O) RATE, subject to the general deductible.
- Covered wellness benefits associated with the preventive care office visit have been enhanced as described below and are now the same as covered wellness benefits under the PPO option, but with a lower annual maximum.
  - Associated lab work and diagnostic tests for preventive care visits will be paid at 100% of the H/O rate with no deductible, up to a maximum of \$200 per year per person. The wellness benefit has increased from \$100 per person per Plan Year to \$200 per person per Plan Year for the expanded list of covered lab work and diagnostic tests, including such services as PSAs, EKGs, and pap smears.
  - Coverage for screening mammograms will be increased to \$125 per Plan Year. Deductibles and coinsurance amounts will continue to be waived.

You may view recommended guidelines online for coverage of preventive care lab work and diagnostic tests. Visit [www.healthygeorgia.com](http://www.healthygeorgia.com) or call the Members Service line at 800-483-6983 (outside Atlanta) or 404-233-4479 (inside Atlanta). The list of covered services will be the same for both the PPO and High Options.

### Comparison Chart

The next *UPDATER* section is a detailed comparison of Standard PPO, PPO Choice, and High Option benefits. To make viewing the information easier, we formatted the comparison chart in a “landscape” view.

# Summary Description of the PPO and High Options

## How the PPO Options Compare to the High Option

This chart is designed to help you make an informed enrollment decision among the Standard PPO, PPO Choice, and the High Options. If you are eligible for HMO coverage and want to compare these benefits with your other options, contact your personnel/payroll office for a *Health Plan Decision Guide Package*.

Benefits		PPO Options		High Option
Description of Plan	In-Network/Georgia	In-Network/Out-of-State	Out-of-Network	
<b>Providers of Service</b>	Network providers are located in the Georgia service area, which consists of the state of Georgia, the Chattanooga, Tennessee area, including Bradley County, and Phenix City, Alabama. Provider directories are in your personnel/payroll office for viewing; for the most up-to-date listing, log on to <a href="http://www.healthygeorgia.com">www.healthygeorgia.com</a> . Referrals for specialty care are not required.	Network providers are located outside of the Georgia service area. Provider directories are available online at <a href="http://www.healthygeorgia.com">www.healthygeorgia.com</a> and then by clicking onto the Beech Street provider link or by calling Member Services. Referrals for specialty care are not required.	Any lawfully operated hospital, licensed physician, pharmacy or other qualified medical provider. Referrals for specialty care are not required. Balance billing may apply.	Any lawfully operated hospital, licensed physician, licensed pharmacy or other qualified medical provider. Referrals for specialty care are not required. Charges from non-participating providers are subject to balance billing.
<b>Description of Plan</b>	A comprehensive network of doctors, ANCLLARY PROVIDERS, and hospitals that have agreed to offer quality medical care and services at discounted rates with no balance billing. Services must be received in the Georgia service area from an MRN/Georgia 1 <sup>st</sup> network provider to receive the 90% level of coverage.	You have the flexibility to obtain services outside the Georgia service area from a Beech Street national network provider and receive the 80% level of benefit coverage, with no balance billing. Beech Street providers are not available to members inside the Georgia service area.	You have the flexibility to see any qualified provider of medical services, regardless of the provider's location, and receive the 60% level of benefit coverage. You are subject to balance billing for charges above the Plan's allowed amounts.	You have the flexibility to receive care from any qualified health care professional, but you are subject to balance billing from non-participating physicians and from out-of-state hospitals if billed charges exceed the Plan's allowed amounts.

Benefits	PPO Options			High Option
	In-Network/Georgia	In-Network/Out-of-State	Out-of-Network	
<b>Medical Benefits:</b>				
<b>Maximum Lifetime Benefit</b>	\$2 million	\$2 million	\$2 million	\$2 million
<b>Preexisting Conditions</b> (First year in Plan, subject to HIPAA. See page 28 for details.)	\$1,000	\$1,000	\$1,000	\$1,000
<b>Lifetime Benefit for Treatment of:</b>				
Temporomandibular Joint Dysfunction	\$1,100	\$1,100	\$1,100	\$1,100
Substance Abuse	3 Episodes	3 Episodes	3 Episodes	3 Episodes
Organ and Tissue Transplants	\$500,000	\$500,000	\$500,000	\$500,000
Home Hyperalimantation	\$500,000	\$500,000	\$500,000	\$500,000
<b>Deductibles/Copayments:</b>				
Individual Deductible per Person per Plan Year	\$300	\$400*	\$400*	\$300
Family Maximum per Plan Year	\$900	\$1,200*	\$1,200*	\$900
Hospital Deductible per Admission—excluding BHS and Transplant Program	No separate hospital deductible.	No separate hospital deductible.	No separate hospital deductible.	\$100

\*PPO in-network/out-of-state deductibles and stop-loss limits are combined with PPO out-of-network deductibles and stop-loss limits.

Benefits	PPO Options			High Option
	In-Network/Georgia	In-Network/Out-of-State	Out-of-Network	
<b>Deductibles/Copayments: (Continued)</b>				
Hospital Deductible per Admission—BHS and Transplant Program	\$100	\$100	\$100	\$100
Emergency Room Copayment	\$60; \$40 if referred by NurseCall 24; waived if admitted within 24 hours.	\$60; \$40 if referred by NurseCall 24; waived if admitted within 24 hours.	\$60; \$40 if referred by NurseCall 24; waived if admitted within 24 hours.	\$60; \$40 if referred by NurseCall 24; waived if admitted within 24 hours.
Urgent Care Center Copayment	\$35	\$35	Not applicable.	Not applicable.
<b>Annual Out-of-Pocket Maximums (Stop-Loss):</b>				
Individual (you or one of your dependents)	\$1,000	\$2,000*	\$2,000*	\$1,500
Family (you and your dependents)	\$2,000	\$4,000*	\$4,000*	\$2,500
BHS Program (per patient)	\$2,500	\$2,500	No stop-loss	\$2,500
<p>Services covered under the PPO from a participating in-network/Georgia provider will apply only to the in-network/Georgia deductible and stop-loss amounts.</p> <p>When a member elects to use both in-network/Georgia and in-network/out-of-state or out-of-network providers, payments made toward deductibles and stop-loss limits will be applied separately to either the in-network/Georgia or the combined in-network/out-of-state and out-of-network amounts.</p> <p><b>*PPO in-network/out-of-state deductibles and stop-loss limits are combined with PPO out-of-network deductibles and stop-loss limits.</b></p> <p>Lifetime benefit maximums are combined totals among the PPO Options and High Option. Some PPO annual maximums and limitations are combined totals. Annual dollar and visit limitations are based on a July 1st to June 30th fiscal year.</p>				

Benefits	PPO Options			High Option
	In-Network/Georgia	In-Network/Out-of-State	Out-of-Network	
<b>Covered Services</b>				
<p><b>Primary Care Physician or Specialist Office or Clinic Visits</b></p> <ul style="list-style-type: none"> <li>Treatment of illness or injury</li> </ul>	<p>Office visits for both primary and specialty care are covered at 100% of network rate after a per-visit copayment of \$20 is paid. Not subject to general deductible. Charges for services associated with the office visit, such as lab work, are subject to the general deductible and coinsurance.</p>	<p>Office visits for both primary and specialty care are covered at 100% of network rate after a per-visit copayment of \$20 is paid. Not subject to general deductible. Charges for services associated with the office visit, such as lab work, are subject to the general deductible and coinsurance.</p>	<p>Office visits for both primary and specialty care are covered at 60% of the out-of-network rate (see Glossary), subject to general deductible.</p>	<p>Office visits for both primary and specialty care are covered at 90% of the H/O rate (see Glossary), subject to general deductible.</p>
<p><b>Primary Care Physician or Specialist Office or Clinic Visits for the following:</b></p> <ul style="list-style-type: none"> <li>Wellness care/Preventive health care</li> <li>Well-newborn exam</li> <li>Well-child exams and immunizations</li> <li>Annual physicals</li> <li>Annual gynecological exams</li> </ul>	<p>100% of network rate for office visit charge after a per-visit copayment of \$20.</p> <p>100% of network rate for lab and test charges associated with office visit, up to a maximum of \$500 per person per year (at network rate); maximum combined with in-network/out-of-state benefit. Not subject to general deductible.</p> <p>Covered lab and tests to include such services as mammograms, prostate screenings/PSAs and pap smears. Covered according to preventive age schedules and medical history. View recommended guidelines online at <a href="http://www.healthypeorgia.com">www.healthypeorgia.com</a> or <a href="http://www.healthypeorgia.com">www.healthypeorgia.com</a></p>	<p>100% of network rate for office visit charge after a per-visit copayment of \$20.</p> <p>100% of network rate for lab and test charges associated with office visit, up to a maximum of \$500 per person per year (at network rate); maximum combined with in-network/Georgia benefit. Not subject to general deductible.</p> <p>Covered lab and tests to include such services as mammograms, prostate screenings/PSAs and pap smears. Covered according to preventive age schedules and medical history. View recommended guidelines online at <a href="http://www.healthypeorgia.com">www.healthypeorgia.com</a> or <a href="http://www.healthypeorgia.com">www.healthypeorgia.com</a></p>	<p>Not covered. Charges do not apply to general deductible or annual stop-loss limits.</p>	<p>90% of H/O rate for office visit charges. Subject to general deductible.</p> <p>100% of H/O rate for lab and test charges associated with office visit, up to a maximum of \$200 per person per year (at H/O rate). An additional \$125 annual benefit for screening mammogram. Not subject to general deductible.</p> <p>Covered lab and tests to include such services as mammograms, prostate screenings/PSAs and pap smears. Covered according to preventive age schedules and medical history. View recommended guidelines online at <a href="http://www.healthypeorgia.com">www.healthypeorgia.com</a> or <a href="http://www.healthypeorgia.com">www.healthypeorgia.com</a></p>

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Benefits	PPO Options			High Option
	In-Network/Georgia	In-Network/Out-of-State	Out-of-Network	
<b>Covered Services (Continued)</b>	(continued from p. 15)	(continued from p. 15)	(continued from p. 15)	(continued from p. 15)
<b>Maternity Treatment</b> (prenatal and postnatal)	call member services at (800) 483-6983 (outside Atlanta) or (404) 233-4479 (inside Atlanta).  90% of network rate after an initial visit copayment of \$20. Not subject to general deductible.	call member services at (800) 483-6983 (outside Atlanta) or (404) 233-4479 (inside Atlanta).  80% of network rate after an initial visit copayment of \$20. Not subject to general deductible.	call member services at (800) 483-6983 (outside Atlanta) or (404) 233-4479 (inside Atlanta).  60% of out-of-network rate. Subject to general deductible.	call member services at (800) 483-6983 (outside Atlanta) or (404) 233-4479 (inside Atlanta).  90% of H/O rate. Subject to general deductible.
<b>Outpatient Surgery</b> in the office setting	90% of network rate. Subject to general deductible.	80% of network rate. Subject to general deductible.	60% of out-of-network rate. Subject to general deductible.	90% of H/O rate. Subject to general deductible.
<b>Laboratory, X-rays, and diagnostic tests for the treatment of an illness or injury</b> (recertification may be required)	90% of network rate. Subject to general deductible.	80% of network rate. Subject to general deductible.	60% of out-of-network rate. Subject to general deductible.	90% of H/O rate. Subject to general deductible.
<b>Injections, including Medications</b> (covered under medical benefits)	90% of network rate. Subject to general deductible.	80% of network rate. Subject to general deductible.	60% of out-of-network rate. Subject to general deductible.	90% of H/O rate. Subject to general deductible.
<b>Allergy Shots and Serum</b>	100% for shots and serum. (If physician is seen, visit is treated as an office visit subject to the per-visit copayment of \$20.) Not subject to the general deductible.	100% for shots and serum. (If physician is seen, visit is treated as an office visit subject to the per-visit copayment of \$20.) Not subject to the general deductible.	60% of out-of-network rate. Subject to general deductible.	90% of H/O rate. Subject to general deductible.
<b>Allergy Testing</b>	90% of network rate. Subject to general deductible.	80% of network rate. Subject to general deductible.	60% of out-of-network rate. Subject to general deductible.	90% of H/O rate. Subject to general deductible.

Benefits	PPO Options			High Option
	In-Network/Georgia	In-Network/Out-of-State	Out-of-Network	
<b>Covered Services (Continued)</b>				
<p><b>Physician Services Furnished in a Hospital</b> (precertification is required)</p> <ul style="list-style-type: none"> <li>Surgery (including charges by surgeon, anesthesiologist, pathologist, and/or radiologist)</li> </ul>	<p>90% of the network rate. Subject to general deductible. Certain outpatient surgical procedures and diagnostic tests require precertification from the MCP or reimbursement is reduced.</p> <p>Note: Members are responsible for precertification for those services performed by Beech Street providers.</p>	<p>80% of the network rate. Subject to general deductible. Certain outpatient surgical procedures and diagnostic tests require precertification from the MCP or reimbursement is reduced.</p> <p>Note: Members are responsible for precertification, including those services performed by Beech Street providers.</p>	<p>60% of the out-of-network rate. Subject to general deductible. Certain outpatient surgical procedures and diagnostic tests require pre-certification from the MCP or reimbursement is reduced.</p> <p>Note: Members are responsible for precertification.</p>	<p>90% of H/O rate. Subject to general deductible. Certain outpatient surgical procedures and diagnostic tests require precertification from the MCP or reimbursement is reduced.</p> <p>Note: Members are responsible for precertification for services from non-participating physicians and non-contracted/out-of-state hospitals.</p>
<ul style="list-style-type: none"> <li>Well-newborn care</li> </ul>	<p>100% of network rate.</p>	<p>100% of network rate.</p>	<p>Not covered.</p>	<p>Not covered.</p>
<p><b>Physician Services that are for an Emergency as Defined and Approved by the Plan</b></p>	<p>90% of network rate. Subject to general deductible.</p>	<p>90% of network rate. Subject to in-network/Georgia deductible.</p>	<p>90% of network rate. Subject to in-network/Georgia deductible and to balance billing.</p>	<p>90% of H/O rate. Subject to general deductible and to balance billing from non-participating providers.</p>
<p><b>Outpatient Surgery-Facility</b></p>	<p>90% of network rate. Subject to general deductible.</p>	<p>80% of network rate. Subject to general deductible.</p>	<p>60% of out-of-network rate. Subject to general deductible.</p>	<p>90% of H/O rate. Subject to general deductible.</p>

Benefits	PPO Options			High Option
	In-Network/Georgia	In-Network/Out-of-State	Out-of-Network	
<b>Covered Services (Continued)</b>				
<b>Hospital Services for Non-Emergency Services as Defined by the Plan</b> <ul style="list-style-type: none"> <li>Inpatient Care, including inpatient short-term rehabilitation services (precertification required)</li> </ul>	90% of network rate for semi-private, ICU, CCU, and miscellaneous hospital charges. Subject to general deductible. Not subject to balance billing. In-network hospitals precertify inpatient admissions. General deductible and coinsurance can be applied to the stop-loss limit.	80% of network rate for semi-private, ICU, CCU, and miscellaneous hospital charges. Subject to general deductible. Not subject to balance billing. Member is responsible to precertify inpatient admissions. General deductible and coinsurance can be applied to the stop-loss limit.	60% of out-of-network rate for semi-private, ICU, CCU, and miscellaneous hospital charges. Subject to general deductible. Charges subject to balance billing. Member is responsible to precertify inpatient admissions. General deductible and coinsurance can be applied to the stop-loss limit.	90% of the H/O rate after a \$100 per admission hospital deductible is met for semi-private, ICU, CCU, and miscellaneous hospital charges. Charges from contracted hospitals are not subject to balance billing. If an out-of-state/non-contracted hospital is used, charges are subject to balance billing and the member is responsible to precertify inpatient admissions. Deductibles and coinsurance can be applied to the stop-loss limit.
	<ul style="list-style-type: none"> <li>Outpatient Services, including non-emergency, emergency room (E/R) services.</li> </ul>	90% of network rate. Subject to general deductible and, for non-emergency E/R services, a per-visit emergency room copayment of \$60. The copayment is reduced to \$40 if referred by NurseCall 24. If admitted within 24 hours, the copayment is not charged.	80% of network rate. Subject to general deductible and, for non-emergency E/R services, a per-visit emergency room copayment of \$60. The copayment is reduced to \$40 if referred by NurseCall 24. If admitted within 24 hours, the copayment is not charged.	60% of out-of-network rate. Subject to general deductible and, for non-emergency E/R services, a per-visit emergency room copayment of \$60. The copayment is reduced to \$40 if referred by NurseCall 24. If admitted within 24 hours, the copayment is not charged.
<ul style="list-style-type: none"> <li>Well-newborn care</li> </ul>	100% of network rate.	100% of network rate.	Not covered.	90% of H/O rate. Subject to a per admission deductible of \$100.

Benefits	PPO Options			High Option
	In-Network/Georgia	In-Network/Out-of-State	Out-of-Network	
<b>Covered Services (Continued)</b>				
<p><b>Hospital Services for an Emergency as Defined and Approved by the Plan</b></p> <ul style="list-style-type: none"> <li>• Treatment of an Emergency</li> </ul>	90% of network rate after a per-visit emergency room copayment of \$60. The copayment is reduced to \$40 if referred by NurseCall 24. If admitted within 24 hours, the copayment is not charged. General deductible applies.	90% of network rate after a per-visit emergency room copayment of \$60. The copayment is reduced to \$40 if referred by NurseCall 24. If admitted within 24 hours, the copayment is not charged and the member (or designee) must contact the MCP within one business day of admission. In-network/Georgia deductible applies.	90% of network rate after a per-visit emergency room copayment of \$60. The copayment is reduced to \$40 if referred by NurseCall 24. If admitted within 24 hours, the copayment is not charged and the member (or designee) must contact the MCP within one business day of admission. In-network/Georgia deductible applies. Charges subject to balance billing.	90% of H/O rate after a per-visit emergency room copayment of \$60. The copayment is reduced to \$40 if referred by NurseCall 24. If admitted within 24 hours, the copayment is not charged. Hospital deductible applies. If admitted to non-contracted/out-of-state hospital, charges are subject to balance billing and member (or designee) must contact the MCP within one business day.
<p><b>Urgent Care Services</b> (in an approved urgent-care center)</p>	100% of network rate after a per-visit copayment of \$35. Not subject to general deductible.	100% of network rate after a per-visit copayment of \$35. Not subject to general deductible.	80% of out-of-network rate. Subject to general deductible.	90% of H/O rate. Subject to general deductible.
<p><b>Skilled Nursing Facility Services</b></p>	Not covered.	Not covered.	Not covered.	Not covered.

Benefits	PPO Options			High Option
	In-Network/Georgia	In-Network/Out-of-State	Out-of-Network	
<b>Covered Services (Continued)</b>				
<b>Home Nursing Care</b> (Limited to \$7,500 per year; limit is a combined total in PPO Options. Plan-approved Letter of Medical Necessity required. If in lieu of hospitalization, additional benefits may be approved)	90% of network rate after the general deductible has been met for two hours of skilled home care per day by RN or LPN, if medically necessary and ordered by a physician; up to a maximum of \$7,500 per person per Plan Year. Home nursing care charges are not applied to the stop-loss limit.	80% of network rate after the general deductible has been met for two hours of skilled home care per day by RN or LPN, if medically necessary and ordered by a physician; up to a maximum of \$7,500 per person per Plan Year. Home nursing care charges are not applied to the stop-loss limit.	60% of out-of-network rate after the general deductible has been met for two hours of skilled home care per day by RN or LPN, if medically necessary and ordered by a physician; up to a maximum of \$7,500 per person per Plan Year. Home nursing care charges are not applied to the stop-loss limit.	90% of H/O rate after the general deductible has been met for two hours of skilled home care per day by RN or LPN, if medically necessary and ordered by a physician; up to a maximum of \$7,500 per person per Plan Year. Home nursing care charges are not applied to the stop-loss limit.
<ul style="list-style-type: none"> <li>Home hyperalimentation (Must be precertified; lifetime benefit maximum of \$500,000)</li> </ul>	90% of network rate. Subject to general deductible.	80% of network rate. Subject to general deductible.	60% of out-of-network rate. Subject to general deductible.	90% of H/O rate. Subject to general deductible.
<b>Hospice Care</b> (Precertification required; if in lieu of hospitalization, additional benefits may be approved)	100% of network rate. Subject to general deductible and lifetime benefit maximum approved by Medicare.	100% of network rate. Subject to general deductible and lifetime benefit maximum approved by Medicare.	60% of out-of-network rate. Subject to general deductible and lifetime benefit maximum approved by Medicare.	100% of H/O rate. Subject to general deductible; hospital deductible, if in lieu of hospitalization; and lifetime benefit maximum approved by Medicare.
<b>Ambulance Services</b> (Limited to emergency services as defined by Plan)	90% of network rate. Subject to general deductible.	90% of network rate. Subject to in-network/Georgia deductible.	90% of network rate. Subject to in-network/Georgia deductible and balance billing.	90% of H/O rate. Subject to general deductible.

Benefits	PPO Options			High Option	
	In-Network/Georgia	In-Network/Out-of-State	Out-of-Network		
<b>Covered Services (Continued)</b>					
<b>Durable Medical Equipment</b> (requires Plan-approved Letter of Medical Necessity)	Covered at 90% of network rate after the general deductible is met, for rental or purchase of certain basic durable medical equipment from a participating provider that is medically necessary and is approved by the SHBP. Balance billing does not apply when using a participating provider.	Covered at 80% of network rate after the general deductible is met, for rental or purchase of certain basic durable medical equipment from a participating provider that is medically necessary and is approved by the SHBP. Balance billing does not apply when using a participating provider.	Covered at 60% of out-of-network rate after the general deductible is met, for rental or purchase of certain basic durable medical equipment that is medically necessary and is approved by the SHBP. Balance billing may apply.	Covered at 90% of H/O rate after the general deductible is met, for rental or purchase of certain basic durable medical equipment that is medically necessary and is approved by the SHBP. Balance billing may apply.	
	<b>Outpatient Self-Management Training and Educational Services</b> (Available for diabetes, oncology, congestive heart failure, and asthma)	100% of negotiated rate. Not subject to general deductible. Covered only when participating in approved disease state management program.	80% of negotiated rate. Not subject to general deductible. Covered only when participating in approved disease state management program.	Not applicable. Covered only when participating in approved disease state management program.	100% of negotiated rate. Not subject to general deductible. Covered only when participating in approved disease state management program.
	<b>Outpatient Short-Term Rehabilitation Services</b> (Physical, Speech, and Occupational Therapies; Cardiac Rehabilitation)	90% of network rate after general deductible is met for up to 40 visits per Plan Year.	80% of network rate after general deductible is met for up to 40 visits per Plan Year.	60% of out-of-network rate after general deductible is met for up to 40 visits per Plan Year.	90% of H/O rate after general deductible is met for up to 40 visits per Plan Year.

Benefits	PPO Options			High Option
	In-Network/Georgia	In-Network/Out-of-State	Out-of-Network	
<b>Covered Services (Continued)</b>				
<b>Dental and Oral Care</b> (Lifetime benefit limit for treatment of temporomandibular joint dysfunction, or TMJ, is combined for the PPO Options and High Option.)	Benefits are provided for dental work done only in connection with the prompt repair of damage to natural tissue or natural teeth and for specified oral surgical procedures. Payment for covered dental services is 90% of network rate (after the general deductible is met). Extraction of impacted teeth is not covered. Lifetime benefit limit for treatment of temporomandibular joint dysfunction (TMJ) is \$1,100. Hospital charges for these procedures are covered as are other hospital costs. Network providers may not be available for all covered services; charges are paid at 90% of network rates, subject to balance billing.	Benefits are provided for dental work done only in connection with the prompt repair of damage to natural tissue or natural teeth and for specified oral surgical procedures. Payment for covered dental services is 80% of network rate (after the general deductible is met). Extraction of impacted teeth is not covered. Lifetime benefit limit for treatment of temporomandibular joint dysfunction (TMJ) is \$1,100. Hospital charges for these procedures are covered as are other hospital costs. Network providers may not be available for all covered services; charges are paid at 80% of network rates, subject to balance billing.	Benefits are provided for dental work done only in connection with the prompt repair of damage to natural tissue or natural teeth and for specified oral surgical procedures. Payment for covered dental services is 60% of out-of-network rate (after the general deductible is met). Extraction of impacted teeth is not covered. Lifetime benefit limit for treatment of TMJ is \$1,100. Hospital charges for these procedures are covered as are other hospital costs.	Benefits are provided for dental work done only in connection with the prompt repair of damage to natural tissue or natural teeth and for specified oral surgical procedures. After meeting the general deductible, payment for covered dental services is 90% of H/O rate. Extraction of impacted teeth is not covered. Lifetime benefit limit for treatment of TMJ is \$1,100. Hospital charges for these procedures are covered as are other hospital costs.
<b>Chiropractic Care</b> (limited to 40 visits per year)	90% of network rate. Subject to general deductible.	80% of network rate. Subject to general deductible.	60% of out-of-network rate. Subject to general deductible.	90% of H/O rate. Subject to general deductible.

Benefits	PPO Options			High Option
	In-Network/Georgia	In-Network/Out-of-State	Out-of-Network	
<b>Covered Services (Continued)</b>				
<p><b>Prescription Drugs</b> (Purchased at an Express Scripts network pharmacy, regardless of Health Plan Option)</p>	<p>\$10 copayment for generic drugs; \$20 copayment for preferred brand name drugs; 20% coinsurance for non-preferred brand name drugs, with a \$35 minimum and \$75 maximum copayment.</p> <p>When a member chooses a preferred brand name or non-preferred brand name drug over its generic equivalent, the member will be responsible to “pay-the-difference” between the two in addition to the generic copayment. If the treating physician justifies the preferred brand or non-preferred brand over the generic, the “pay-the-difference” feature will not apply. The member will be responsible for paying the preferred brand or non-preferred brand copayment amount. If the drug’s usual and customary cost is less than the copayment, the member pays the drug’s usual and customary cost. Copayments are based on supplies of up to 30 days; some drugs are limited to a standard other than 30-day supplies. You may obtain up to a 90-day supply for your initial prescription and for each refill (if written for 90 days) with one copayment per 30-day supply for drugs listed as maintenance drugs under the Plan. The deductible does not apply to prescription drug benefits. Copayments do not apply toward stop-loss limits. Express Scripts has a national network of participating pharmacies. Call Express Scripts at 877-650-9342 for locations across the country.</p>			
<p><b>Prescription Drugs</b> (Purchased at an out-of-network pharmacy, regardless of Health Plan Option)</p>	<p>Member must pay charges at point of sale and submit a paper claim with a pharmacy receipt. Members will be reimbursed at the pharmacy network rate less the required copayment for those drugs covered by the Plan. Limitations and restrictions indicated above also apply to covered drugs purchased out-of-network. Charges are subject to balance billing.</p>			
<p><b>Behavioral Health Care</b> (With BHS referral, regardless of Health Plan Option)</p>	<p>Inpatient hospital services for mental health and substance abuse are covered at 90% for up to a combined total of 60 days per person, per Plan Year; associated professional fees are covered at 80% for up to 60 visits. Partial/Day hospitalization is covered at 90% for up to 30 days/visits per Plan Year. Outpatient professional services for mental health and substance abuse are covered at 80% for up to 50 visits per Plan Year. Visit limitation includes up to three brief situational counseling sessions covered at 100% without deductible. Substance abuse treatment is limited to three episodes per lifetime. All eligible charges are subject to deductibles (\$300 PPO in-network/Georgia; \$300 High Option general deductible and \$100 per confinement hospital deductible) and to a separate stop-loss limit of \$2500 per person, per Plan Year. See the November 1, 1995, Plan booklet for full details on coverage provisions and exclusions. BHS has a national network of providers. BHS providers are not part of the PPO or PPP networks.</p>			

Benefits	PPO Options			High Option
	In-Network/Georgia	In-Network/Out-of-State	Out-of-Network	
<b>Covered Services (Continued)</b>				
<p><b>Behavioral Health Care</b> (Without BHS referral, regardless of Health Plan Option)</p>	<p>Inpatient hospital services for mental health and substance abuse are covered at 60% of the average network per diem rate when certified as medically necessary care for up to a combined total of 60 days per Plan Year; associated professional fees are covered at 50% of the network rate for up to 25 visits per Plan Year. Outpatient professional (MD/PhD) services for mental health and substance abuse are covered at 50% of the network rate for up to 25 visits per Plan Year. Substance abuse treatment with BHS certification is limited to three episodes per lifetime. All eligible charges are subject to deductibles and do not accumulate toward any stop-loss limit. Balance billing may apply. See the November 1, 1995, Plan booklet for full details on coverage provisions and exclusions.</p>			
<p><b>Transplant Care</b></p>	<p>The level of benefit coverage is based on whether or not you select a contracted transplant center, regardless of your Health Plan option. At contracted centers, the level of benefit coverage is 90% of the network rate. At non-contracting centers, the level of benefit coverage is 60% of the network rate for eligible services.</p>			

—End of Summary Description—

If you have questions regarding benefit coverage, contact the Member Services Unit at 800-483-6983 (outside Atlanta) or 404-233-4479 (inside Atlanta).

# Service Area Changes for SHBP Options

## Standard PPO and PPO Choice Options

Effective July 1, 2001, the PPO will no longer be restricted to members living or working in selected zip code areas. All members eligible for SHBP coverage may enroll in the Standard PPO or PPO Choice Options.

The Georgia service area includes the state of Georgia and the border communities of the Chattanooga, Tennessee area, including Bradley County; and Phenix City, Alabama. If you receive services from a provider that is not located in the one of the zip codes listed below, then you would not be able to receive the in-network/Georgia level of benefits coverage, unless you required emergency services. Also remember that you must use an MRN/Georgia 1<sup>st</sup> provider located in one of the listed zip codes in order to receive the 90% level of benefit coverage.

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

## HMO Service Area Closures—Aetna US Healthcare

Aetna US Healthcare coverage in the Augusta and Macon service areas will not be available on or after July 1, 2001. Aetna members living or working in the counties listed below will need to select another available coverage option during the upcoming annual Open Enrollment period (for coverage effective July 1, 2001). **If you do not indicate another option during Open Enrollment, either in writing (on the SHBP Membership Form or the Georgia Merit System Option Statement), or online at the appropriate Web site—you will automatically be placed in the Standard PPO Option.**

**Augusta Service Area:** Burke, Columbia, Jefferson, Lincoln, McDuffie, and Richmond counties

**Macon Service Area:** Baldwin, Bibb, Houston, Jones, Peach, Pulaski, and Twiggs counties

## MCP Outpatient Precertification Program Changes

Effective July 1, 2001, the outpatient precertification list last published in the Spring 2000 *UPDATER* will be replaced with the updated list below. There are no changes to procedure categories. However, a number of codes were either deleted or added. All new procedure codes are shown in ***bold italics***.

If you are a PPO Option member whose treatment is being coordinated through an in-network/Georgia (MRN/Georgia 1<sup>st</sup>) provider, that provider is responsible for precertifying the tests and procedures listed below. Your in-network/Georgia provider also is responsible for precertification if you are a PPO Choice Option member whose treatment is being coordinated through a nominated provider that has been approved by the PPO. You are responsible for ensuring that either you or your provider precertifies the tests and procedures listed below if:

- you are a PPO Option member using either 1) an in-network/out-of-state (Beech Street) provider; 2) an out-of-network provider; or 3) a provider that has not been approved by the PPO; or
- you are a High Option member using either a non-participating physician or an out-of-state/non-contracted hospital.

Failure to follow MCP rules will result in penalties, in the form of reduced benefits from the Health Plan.

*Retirees and covered dependents with primary coverage through Medicare are not required to precertify procedure codes on this list. If you are a retiree, please refer to the Spring 2001 UPDATER for Retirees.*

### **CAT or CT Scans (except for brain and spine):**

70480 through 70482; 70490 through 70492; 71250 through 71270; ***71275***; 72192 through 72194; 73200 through 73202; 73700 through 73702; 74150 through 74170; 76375; 76380.

### **Colonoscopies:**

45378 through 45385.

### **Endoscopies:**

43234; 43235; 43239.

### **Esophageal Surgeries:**

43280; 43289; 43324; 43325; ***43326***.

### **Laparoscopies and/or Peritoneoscopies:**

49320; 49329; 58550; 58551; 58578; 58660; 58661; 58662; 58679.

### **Magnetic Resonance Angiography (MRAs) :**

***70544 through 70546; 70547 through 70549***; 71555; 72159; 72198; 73225; 73725; 74185.

### **Magnetic Resonance Imaging (MRIs):**

70336; 70540 ***through 70543***; 70551 through 70553; 71550 through 71552; 72141 through 72158; ***72195 through 72197; 73218 through 73220; 73221 through 73223; 73718 through 73720; 73721 through 73723***; 74181 through 74183; 75552 through 75556; 76093; 76094; ***76375***; 76400.

### **Nasal Surgeries:**

30400 through 30520; 30620; 30930.

### **Sleep Studies:**

95805; 95806; 95807; 95808; 95810; 95811.

### **Uvulopalatopharyngoplasties:**

42120; 42140; 42145; 42299; 42950.

You may want to share this list with your physician. If either you or a covered dependent plans to undergo one of the listed tests or procedures, you or your doctor (see above) must call the Medical Certification Program in advance for precertification. The toll-free number outside of the Atlanta area is 800-762-4535, and the number in the Atlanta area is 770-438-9770.

## Women's Health and Cancer Rights Act of 1998

Each year, the Georgia Department of Community Health is required to notify you of your rights under the federal law known as the Women's Health and Cancer Rights Act of 1998. The Act generally requires group health plans and insurance companies that provide mastectomy-related benefits or services to provide Plan participants or beneficiaries with certain benefits for reconstructive surgery and complications related to a mastectomy.

When a group health plan participant or beneficiary receives benefits in connection with a mastectomy for the treatment of cancer and elects breast reconstruction in connection with the mastectomy, the act provides coverage for the following:

1. Reconstruction of the breast on which the mastectomy has been performed;
2. Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
3. Prostheses and treatment of physical complications at all stages of mastectomy, including lymphedemas.

Coverage for these benefits or services will be provided in a manner determined in consultation with the attending physician and the patient.

Coverage for the mastectomy-related services or benefits provided under the Act will be subject to the same deductibles and coinsurance provisions that apply to other medical or surgical benefits provided under the SHBP.

## High Option

For the High Option, these provisions are generally a \$100 inpatient hospital deductible (per *admission*), and a 10% coinsurance payment on hospital charges, up to the limits on member's out-of-pocket costs.

## PPO Option

For in-network/Georgia Standard PPO Option coverage, these provisions generally include a 10% coinsurance payment after meeting either the general deductible of \$300 per person or the \$900 family maximum. For in-network/out-of-state PPO Option coverage, these provisions generally include a 20% coinsurance payment after meeting either the general deductible of \$400 per person or the \$1,200 family maximum. Out of the PPO network, these provisions generally include a 40% coinsurance payment after meeting either the deductible of \$400 per person or the \$1200 family maximum, which is combined with the in-network/out-of-state deductibles. Out-of-pocket costs for covered expenses are limited to respective stop-loss amounts.

If you are a covered member or qualified dependent under the SHBP, and you require a mastectomy, the Plan's coverage includes all treatments for which coverage is required under the Women's Health and Cancer Rights Act.

## HIPAA Annual Notice

Each year the SHBP is required to notify you of certain rights available to you under the Health Insurance Portability and Accountability Act (HIPAA).

The PPO and High Options contain a preexisting condition (PEC) limitation. Specifically, the Health Plan will not pay charges that are over \$1,000 for the treatment of any preexisting 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 for at least six consecutive calendar months.

In certain situations, SHBP members and dependents can reduce the 12-month preexisting condition limitation period. The reduction is possible by using what is called "creditable coverage" to offset a preexisting condition 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, including coverage under individual health policies and governmental health programs qualifies as creditable coverage.

## For Individuals Gaining SHBP Coverage

The preexisting condition limitation period can be reduced by the length of time that creditable coverage existed, under the following conditions:

- When the Plan member provides the SHBP with a certificate of creditable coverage from one or more former health plans that states when coverage started and ended for each covered person under that plan who now desires SHBP coverage; and

## For Members

- When the time between losing coverage under the most recent former health plan and the later of either your hire date (with the State or school system) or the first day of the waiting period prior to SHBP coverage does not exceed 63 days.

## For Eligible Dependents (including spouses)

- When the time between the day your dependent becomes covered under the SHBP and the last day your dependent had coverage from any former health plan does not exceed 63 days.
- If you or a dependent (including a spouse) had any break in former coverage lasting more than 63 days, you or your dependent will receive creditable coverage only for the period of time after the break ended.

You have the right to obtain a letter of creditable coverage from your former employer(s) to offset the preexisting condition limitation period under the SHBP. The SHBP will evaluate your certificate of coverage or other documentation to determine whether any of the preexisting condition limitation period will be reduced or eliminated. After completing the evaluation, the SHBP will notify you as to how the preexisting condition limitation period will be reduced or eliminated. You have the right to appeal any decision related to a prior creditable coverage determination. If you require assistance in obtaining a letter from a former employer, contact the Plan's eligibility unit at 404-656-6322 in the Atlanta area or at 800-610-1863 outside the Atlanta area.

If you decline enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in the SHBP, provided that you request enrollment within 31 days after your other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 31 days after the marriage, birth, adoption, or placement for adoption.

## Changes to Eligibility Rules

The changes listed below are effective on July 1, 2001. For clarification on the rule change, please see the italicized note under each bullet.

### Changing Your Coverage

If you want to change your coverage from one option to another, you can do so during the Open Enrollment period. In addition to Open Enrollment, you may make mid-year election changes when you have a qualifying event as described in your Plan documents and when you follow Plan rules for making mid-year changes. You can also change options during the year by filing a *Membership Form* with the SHBP prior to or within 31 days after one of these new or updated qualifying events:

- If you, your spouse, or enrolled dependent loses or discontinues health benefit coverage through other employment, Medicaid, or Medicare, the employee may enroll for single or family coverage.

*Discontinuing Medicare coverage is a new qualifying event.*

- You may change to any available option or discontinue coverage when you, your spouse or enrolled dependent changes residence to an area that is not served by the option in which you are enrolled. Documentation of the change in residence may be required.

*A residence change made by your spouse or enrolled dependent may be a qualifying event for you to make coverage changes.*

- You may change to single coverage or discontinue coverage when you, your spouse, or all enrolled dependents become eligible for Medicare or Medicaid. Documentation will be required.

*Acquiring Medicaid coverage is a qualifying event.*

- You may change coverage type (single/family) or discontinue coverage if your spouse or your only enrolled dependent's employment status changes and that change affects his or her eligibility for coverage under a cafeteria or other qualified health plan. Documentation from the employer will be required.

*This rule provides more opportunity for members to change coverage than the previous rule.*

- You may enroll, change to single coverage, or discontinue coverage when your spouse makes an open enrollment election under a qualified employer provided plan and that change creates an overlap or break in health coverage because the other health coverage has a different Plan Year than the SHBP.

Documentation from the employer will be required.

*This rule is a new rule starting July 1, 2001.*

- You may also change to single coverage if a qualified medical child support order (QMCSO) resulting from divorce, legal separation, annulment, or change in legal custody required your former spouse to provide health coverage for all of your enrolled dependents. Documentation of the court order and the effective date of coverage under another health plan will be required. The request must be filed within 90 days following the court order. (The effective date of the change in coverage will be the first of the month following receipt of the request.)

*This rule is a new rule starting July 1, 2001.*

Unless noted otherwise, the effective date of all of the above coverage changes and discontinuations is the first of the month following receipt of your request.

## Glossary of Terms

The Glossary of Terms below supports the new prescription drug copayment program as well as other important definitions referred to in this *UPDATER* and should serve to help clarify details of major changes to the SHBP.

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

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

**Balance Billing:** A dollar amount charged by a provider that is over the Plan's allowed amount for the care or treatment received. Amounts balance billed are the member's responsibility and do not apply to the Plan's stop-loss limits or deductibles. PPO providers do not bill for amounts over the allowed amounts, so members will not be subject to balance billing when using a network PPO provider. However, PPO members are subject to balance billing when using an out-of-network provider. High Option members may be balance billed by physicians who do not participate in the Participating Physicians Program (PPP) and by hospitals that do not have a direct contract with the state.

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

**Brand Necessary:** A physician directive not to substitute a product and to dispense the prescription as written. When the physician indicates “brand necessary” on the prescription, members will not be subject to the “pay-the-difference” rule as described in this document.

**Chemical Equivalents:** Those multiple-source drug products that contain identical amounts of the same active ingredients, in equivalent dosage forms, and meet existing FDA physical/chemical standards.

**Chronic Condition:** A condition which is permanent, leaves residual disability, is caused by nonreversible pathological alteration, requires special training of the patient for rehabilitation, or may be expected to require a long period of supervision, observation, or care.

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

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

**High Option (H/O) Rate:** The dollar amount used in determining an allowed amount in the High Option, which is determined by the SHBP and based in part on contracted rates.

**Hospital-based Physicians:** Anesthesiologists, emergency room physicians, pathologists, and radiologists.

**Legend Drug:** A drug that by law can be obtained only by prescription order and bears the label “Caution: federal law prohibits dispensing without a prescription.”

**Maintenance Drug:** A drug that is used to treat a CHRONIC CONDITION and is taken for the duration of the condition (for example, medications to treat high blood pressure).

**Medically-Necessary Prescription Drugs:** Prescription drug products which are determined by the Plan to be medically appropriate and (1) dispensed pursuant to a prescription order or refill; (2) necessary to meet the basic health needs of the participant; (3) consistent in type, frequency, and duration of treatment with scientifically based guidelines of national medical, research, or health care coverage organizations or governmental agencies; and (4) commonly and customarily recognized as appropriate for

treatment of the illness, injury, sickness, or mental illness. The fact that a provider prescribed a prescription drug product or the fact that it may be the only treatment for a particular illness, injury, sickness, or mental illness does not mean that it is medically necessary.

**National Drug Code (NDC):** A national classification system for identification of drugs, similar to the Universal Product Code (UPC).

**Non-Preferred Brand Name Drug:** A brand name drug that is not on the Plan’s preferred drug list.

**Out-of-Network (OON) Rate:** The dollar amount used in determining an allowed amount in the Standard PPO Option and PPO Choice Option when non-participating providers are used, which is based in part on the network PPO rate.

**Over-the-Counter (OTC) Drug:** A drug product that does not require a prescription order under federal or state law.

**Participating Pharmacy:** A pharmacy that has entered into an agreement with Express Scripts to provide prescription drug products to participants and has agreed to accept specified reimbursement rates. Participating pharmacies also are referred to as network pharmacies.

**Pay-the-Difference Rule:** If your physician prescribes/mandates that you take the brand name drug over the generic, then you will be responsible for the preferred brand name or non-preferred brand name copay. If this is the case, be sure that your physician indicates that only the brand name drug can be dispensed. If you choose the brand name drug over its generic equivalent, you will be required to pay the difference. This means that you will pay the generic copay, plus the difference in cost between the brand name or non-preferred brand name drug and its generic equivalent.

**Preferred Brand Name Drug:** A brand name drug that is on the Plan’s preferred drug list.

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

**Prior Authorization (PA):** The process of obtaining certification of coverage for certain prescription drug products, prior to their dispensing, using guidelines approved by the Plan.

**Usual and Customary (U&C) Pharmacy Charge:** The usual and customary price charged by a pharmacy for a prescription drug product dispensed to a fee-for-service (non-third party) customer. Also referred to as the “retail price.”

## Visit the Web Site for Open Enrollment Changes

### For Your Convenience, Enroll Online!

When you visit the appropriate Web site you will be able to make your coverage selections online. No more filling out paper forms! That saves you time, saves your personnel/payroll staff time, saves the Health Plan time, and conserves our natural resources.

If you participate in the Flexible Benefits program offered through the Georgia Merit System, which includes state agencies and a few regional libraries and educational entities, you may visit their special Web site at [www.gabenefits.org](http://www.gabenefits.org). This Web site will be available April 16 through May 4, 2001, Monday through Sunday, from 7:00 am to 12:00 pm. See your personnel/payroll office for a special "Web Online Instruction" brochure to help you navigate through the Web site. You will be able to make changes to all your Flexible Benefit Program options/coverages offered through the Merit System, plus make your Health Plan coverage selections.

If you do not participate in the Flexible Benefits Program described above, you may visit the State Health Benefit Plan's special Web site at [www.statehealth.org](http://www.statehealth.org) to make your Open Enrollment Health Plan selections online. You can visit this Web site 24 hours a day, 7 days a week from April 16 through May 15, 2001. (Occasionally, the system may be down for routine maintenance late at night.) You will need to refer to your personalized membership change worksheet that you should receive through your personnel/payroll office shortly before Open Enrollment. Look for your personal security code recorded on this worksheet so that you can access the Web site. You'll need this special code to review and then make any requested change, including the addition of dependents if family coverage is selected. The Web site contains instructions on how to enter and confirm your Health Plan coverage selections.

Remember: If you make your selection online, you must obtain the confirmation number to make sure the requested change is processed. If you do not enroll online, be sure to complete the appropriate form(s) available to you from your personnel/payroll office and to complete them by your employer's deadline.

## For More Information

### PPO, PPO Choice, and High Options

- Pharmacy Benefit Program Information: Starting April 16, 2001, contact Express Scripts at 877-650-9342, 24 hours per day, 7 days per week.

### PPO Option/PPO Choice Option

- Benefit and Rate Information: Contact your Personnel/Payroll representative. If a representative is not available, call the Member Services at 800-483-6983 (outside Atlanta) or 404-233-4479 (inside Atlanta)
- TDD line for the hearing impaired 404-842-8073.
- In-Network/Georgia (MRN/Georgia 1<sup>st</sup>) providers—Online PPO Provider Information: See [www.healthygeorgia.com](http://www.healthygeorgia.com) for the most up-to-date information; printed directories are available in your Personnel/Payroll office for viewing or copying.
- In-Network/Out-of-State (Beech Street) providers—On-line PPO Provider Information: [www.healthygeorgia.com](http://www.healthygeorgia.com) with link to Beech Street network providers. Contact the NurseCall 24 program at 800-524-7130, 24 hours per day, 7 days per week, for PPO provider information.
- For online viewing of preventive care health standards, visit the MRN/Georgia 1<sup>st</sup> Web site at [www.healthygeorgia.com](http://www.healthygeorgia.com) (schedule applies to PPO Option members using in-network providers, and to High Option members).

### PPO Choice Option (Only)

- Note: For PPO Choice Option members, only providers located in Georgia with a valid Georgia license may be nominated under the Consumer Choice Option Law.
- Nomination of PPO Provider Information: 800-483-6983 (outside Atlanta) or 404-233-4479 (inside Atlanta)
- Nomination of BHS Provider Information: 800-631-9943; TDD line for the hearing impaired: 678-319-3860
- Nomination of Transplant Provider Information: 800-762-4535 (outside Atlanta); 770-438-9770 (inside Atlanta)

## High Option

- Benefit and Rate Information: Contact your Personnel/Payroll representative. If a representative is not available, call Member Services at 800-483-6983 (outside Atlanta) or 404-233-4479 (inside Atlanta)
- TDD Line for the hearing impaired: 404-842-8073

During the Open Enrollment period—April 16 through May 15—call volume for these numbers is expected to be very high. You may experience time on hold.

## HMO Options

- If you are eligible for HMO option coverage, benefit information is available in the *Health Plan Decision Guide* package available through your Personnel/Payroll office, or by calling the HMO directly.
- Aetna US Healthcare: 800-444-0759

- Aetna US Healthcare Consumer Choice: 800-443-6917
- Aetna US Healthcare Web site: [www.aetnaushc.com](http://www.aetnaushc.com)
- BlueChoice: 800-464-1367
- BlueChoice Web site: [www.bcbsga.com](http://www.bcbsga.com)
- Kaiser Permanente: 404-261-2590
- Kaiser Permanente Web site: [www.kp.org/ga](http://www.kp.org/ga)

## To Change Your Options Online During Open Enrollment

- For employees not participating in the Flexible Benefits Program offered through the Georgia Merit System visit: [www.statehealth.org](http://www.statehealth.org).
- For employees participating in the Flexible Benefits Program offered through the Georgia Merit System visit: [www.gabenefits.org](http://www.gabenefits.org).

This *UPDATER* constitutes official notification to State Health Benefit Plan (SHBP) members of Plan changes and, as such, supersedes any previously published information that conflicts with the material included in this *UPDATER*. Please keep this *UPDATER* with your plan documents for future reference. It will be used—in conjunction with the SHBP Booklet dated November 1, 1995, the HMO Member Handbook dated March 1998, plus any *UPDATER* published after November 1, 1995—to administer the Plan until new booklets are published. If you are disabled and need this information in an alternative format, write the State Health Benefit Plan at P.O. Box 38342, Atlanta, GA 30334, or for TDD Relay Service only, call 800-255-0056 (text telephone) or 800-255-0135 (voice).



GEORGIA DEPARTMENT OF  
COMMUNITY HEALTH

**State Health Benefit Plan**  
**P.O. Box 38342**  
**Atlanta, Georgia 30334**

## IMPORTANT BENEFIT INFORMATION