FOR **RETIREES**

STATE HEALTH BENEFIT PLAN

Retiree Decision Guide 2010

RETIREE OPTION CHANGE PERIOD

October 9–November 10, 2009

Georgia Department of Community Health

Phone Numbers/Contact Information

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

Vendor	Member Services	Web Site
UnitedHealthcare		
Retiree Help Line	877-755-5343	www. welcometouhc.com/shbp
Definity HRA	800-396-6515	www. welcometouhc.com/shbp
HMO, HDHP, OAP	TDD 800-255-0056	www.welcometouhc.com/shbp
CIGNA Healthcare		
Retiree Help Line	800-942-6724	
HRA, OAP, HMO, HDHP	800-633-8519 TDD 800-576-1314	www.mycigna.com/shbp
Pharmacy	Call vendor # listed above	www.dch.georgia.gov/shbp_plans
SHBP Eligibility	404-656-6322 800-610-1863	www.dch.georgia.gov/shbp_plans

Additional Information

Medicare	800-633-4227	www.medicare.gov
Centers for Medicare & Medicaid (CMS)		www.cms.gov
Social Security Administration	800-772-1213	www.ssa.gov

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

Page 3 of this guide contains Plan changes effective January 1, 2010. Prior to the start of the 2010 Plan Year, or shortly thereafter, the Plan will post a new Summary Plan Description (SPD) for each Plan option to the DCH Web site, www.dch.georgia.gov/shbp_plans. This SPD is your official notification of Plan changes effective January 1, 2010. You may print or request a paper copy by calling the Customer Service number on the back of your ID card. Please keep your SPD for future reference. If you are disabled and need this information in an alternative format, call the TDD Relay Service at (800) 255-0056 (text telephone) or (800) 255-0135 (voice) or write the SHBP at P.O. Box 1990, Atlanta, GA 30301-1990.

Georgia Department of
Community Health

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

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

October 1, 2009

Dear State Health Benefit Plan (SHBP) Member:

Welcome to the 2010 Retiree Option Change Period (ROCP). This year the ROCP dates will be October 9–November 10, 2009.

SHBP is committed to providing a comprehensive benefit program while trying to keep prices affordable for all members. During these current financial times, we are faced with decisions that require us to balance our finances while maintaining the standard and quality of care you have come to expect from SHBP. As a result, there will be a number of changes for active members as well as retirees.

Medicare Eligible Retiree Changes:

- SHBP will be offering a second Medicare Advantage with prescription drugs (MAPD) private fee-for-service (PFFS) option. This option will lower your out- out-of-pocket expenses, but it will require a higher premium
- Retirees who are eligible for Medicare because of age or disability will need to enroll in one of the two Medicare Advantage plans to continue to receive the state contribution toward the cost of their health insurance

Non-Medicare Eligible Retiree and Active Member Changes:

- There are a number of changes for the plans offered to our active employees and retirees who are not eligible for Medicare. Please carefully read these changes before making your decision

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

Sincerely,

Rhonda M. Medows, M.D.
Commissioner

Equal Opportunity Employer

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Common Acronyms

CDHP – Consumer Driven Health Plan

CMS – Centers for Medicare and Medicaid Services

COB – Coodination of Benefits

DCH – Georgia Department of Community Health

FSA – Flexible Spending Account

HDHP – High Deductible Health Plan

HMO – Health Maintenance Organization

HRA – Health Reimbursement Arrangement

HSA – Health Savings Account

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

OAP – Open Access Plan: Open Access Plus-CIGNA and Choice Plus-UHC

PCF – Personalized Change Form

PCP – Primary Care Physician

ROCP – Retiree Option Change Period

SHBP – State Health Benefit Plan

SPD – Summary Plan Description

UHC – UnitedHealthcare

Welcome to the Retiree Option Change Period (ROCP) for the State Health Benefit Plan for Coverage Effective January 1, 2010–December 31, 2010

The ROCP dates are October 9 through November 10, 2009. This guide will provide you with a brief explanation of each Plan option, information about changes to SHBP options and change of options for retirees and/or their spouses who are eligible for Medicare. Steps on how to make your health election, information about SHBP's health and wellness programs and initiatives are included as well as a benefits comparison chart. This *Retiree Decision Guide* can be found at www.dch.georgia.gov/shbp_plans or www.oe2010ga.gov.

This year, the retiree decision guide is split into two sections according to your Retiree status. Benefit changes will also be broken down by section. The sections are:

Section 1 – Non-Medicare Eligible Retirees and/or their Spouses and Dependents

This section includes information for retirees and their covered spouses and children who are not eligible for Medicare. This means that no one covered under your coverage with SHBP is eligible for Medicare due to a disability approved by Social Security or by reaching age 65. Retirees not eligible for Medicare have the same options as active employees.

Section 2 – Retirees and/or their Spouses and Dependents Who are Eligible for Medicare

This section includes information for retirees and their covered spouses and children when one or more covered individuals are covered by Medicare because of a disability that qualifies under Social Security guidelines or upon reaching age 65.

Changes for All SHBP Members

- Kaiser Permanente will no longer be offered
- There will be an increase in premiums of 10 percent for all plans except the Medicare Advantage options
- Open Access Plans (OAP): CIGNA Open Access Plus and United Choice Plus; in place of the PPO (See page 6 for more information)

SHBP Plan Changes for 2010

HMO PLAN BENEFITS		
Deductible	**January 1, 2009**	**January 1, 2010**
• Retiree	$400	$600
• Family	$800	$1200
Out-of-Pocket Maximum		
• Retiree	$1500	$2000
• Family	$3000	$4000
Co-insurance	10%	20%
Office Visit Co-pay	$30	$35
Emergency Room Co-pay	$100	$150
Prescription Drug Co-pay	$10/30/75 *2 co-pays for 90 day supply*	$15/40/75 *3 co-pays for 90 day supply*

OPEN ACCESS PLAN BENEFITS – *Replacing PPO**				
	January 1, 2009		**January 1, 2010**	
Deductible	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
• Retiree	$500	$1000	$600	$1200
• Family	$1500	$3000	$1800	$3600
Out-of-Pocket Maximum				
• Retiree	$1500	$3000	$2000	$4000
• Family	$3000	$6000	$4000	$8000
Co-insurance	10%/40%		20%/40%	
Office Visit Co-pay	$30		$35	
Emergency Room Co-pay	$100		$150	
Prescription Drug Co-pay	$10/30/100		$15/40/100	

**CIGNA's Open Access Plus and UnitedHealthcare's Choice Plus Open Access plans replace the PPO.* *See page 6 for further information.*

HRA PLAN BENEFIT		
Deductible	**January 1, 2009**	**January 1, 2010**
• Retiree	$1000	$1100
• Family	$2500	$2750
Out-of-Pocket Maximum		
• Retiree	$2800	$2500
• Family	$4500	$5700
Co-insurance	10%/40%	15%/40%
Prescription Drug Co-pay	10%	15% generic, 25% brand

HDHP PLAN BENEFIT				
	January 1, 2009		**January 1, 2010**	
Deductible	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
• Retiree	$1150	$2300	$1200	$2400
• Family	$2300	$4600	$2400	$4800
Out-of-Pocket Maximum				
• Retiree	$1700	$3800	$1800	$4000
• Family	$2900	$7000	$3100	$7400

Transition of Care – Kaiser Members

- Transition of care may be received if treatment is needed for certain conditions after December 31, 2009. To request transition of care, call your health plan's Customer Service number early in December but no later than December 31, 2009
- If your Kaiser provider is a community specialist and is participating in the new plan you select, benefits for any covered medical services will be covered under the new Plan effective January 1, 2010
- If you have any medical or pharmacy claims for services on or before December 31, 2009, these claims should be filed with Kaiser Permanente by June 30, 2010 at the following address:

Kaiser Permanente
Claims Administration
P.O. Box 190849
Atlanta, GA 31119-0849

No claims will be processed after this date.

Open Access Plan Option

Effective January 1, 2010, as part of the on-going effort to control escalating medical costs, SHBP will offer an Open Access Plan (OAP) instituting a different network provider contract with UnitedHealthcare (UHC). The providers participating in UHC's OAP network are very similar to the one currently being used by the SHBP although you may see some difference. As you may know, the CIGNA option for SHBP members has been an Open Access product since January 1, 2009. The options referred to generically as PPO going forward will be referred to as an Open Access Plan or OAP. When confirming a current provider or searching for a new provider you should use CIGNA's "Open Access Plus" and UHC's "Choice Plus" networks.

The OAPs function like the PPO plans that were offered in 2009, with benefits for in-network and out-of-network coverage. You can choose any network physician or health care professional without a referral, and you will continue to receive the highest level of benefits under your plan when you use in-network providers. In addition, just like the PPO, under the OAP there's no requirement for designating a primary care physician; however, the selection of a primary care physician is highly encouraged. Both CIGNA and UHC OAPs include continued access to a comprehensive network of hospitals, facilities, other health care professionals and pharmacies in Georgia and nationwide receiving benefits for office visits, hospital care (inpatient and outpatient) as well as other benefits previously received under the PPO.

Utilizing this network allows for greater provider negotiated discounts for most services and there's minimal difference in the network makeup. We are confident that this change in network will cause very little disruption or inconvenience to SHBP members.

You will not see any significant differences in the covered services that were offered to you under the PPO options as a result of the options now being referred to as an OAP. However, there are plan design changes that are required in 2010 on all options offered to SHBP members such as deductibles, out-of-pocket limits, co-pays and coinsurance as a result of the State's fiscal situation. Please read your benefit materials carefully to understand the changes on all options.

Coordination of Benefits (COB) Policy Change for the OAP and HRA Options

To make our COB policy consistent across all options, we are changing the COB policy for the OAP and HRA options. This means when you have other group coverage or Medicare and SHBP coverage, the benefit under SHBP will be no greater than it would have been if there was no coverage other than that of SHBP. For example, many times when you went to the doctor, you did not have to pay anything – not even a co-pay. Under the new COB rule, you would owe the co-pay when you go to the doctor for an office visit because the SHBP benefits require a co-pay.

EXAMPLE OF NON-DUPLICATION OF BENEFITS AFTER OTHER COVERAGE AND SHBP DEDUCTIBLES ARE MET:

	2009	2010
Hospital bill for MRI	$2,939.80	$2,939.80
Other Coverage allows	$ 544.27	$ 544.27
Other Coverage pays	$ 435.42	$ 435.42
Member Other Coverage co-insurance	$ 108.85*	$ 108.85*
SHBP allows	$ 544.27	$ 544.27
SHBP applies co-insurance	$ 00.00*	$ 81.64*
SHBP pays	$ 108.85	$ 27.21

** Member responsibility/co-insurance.*

SECTION 1

NON-MEDICARE ELIGIBLE RETIREES/DEPENDENTS

Retirees, their spouses and children who are not eligible for Medicare will have the following SHBP Plan Options available to select from.

CIGNA and UnitedHealthcare Each Offer:

- Health Reimbursement Arrangement (HRA)
- High Deductible Health Plan (HDHP)
- Open Access Plans (OAP): Open Access Plus (CIGNA), Choice Plus (UHC) replaces the PPO
- Health Maintenance Organization (HMO)

What if I Don't Want to Make a Change in Options?

- You will retain the same coverage option and tier (single or family) you currently have unless you are enrolled in a Kaiser option. If you currently have Kaiser and do not go online or complete the Personalized Change Form (PCF) to make a new health selection, you will automatically be enrolled in the CIGNA HRA Option effective January 1, 2010

What Should I Do before I Make My 2010 Benefit Election?

If you want to change your health coverage option or discontinue coverage effective January 1, 2010, you need to take action during this ROCP. If you discontinue coverage, you will not be able to enroll at a later date.

- Evaluate your health care needs
- Kaiser Permanente members must make a selection for a NEW option. If no selection is made, the member will be enrolled in the CIGNA HRA
- If you want to continue with the same coverage you currently have, if offered, including OAP (previously PPO), you don't have to do anything
- Carefully read this *Retiree Decision Guide* for important information about Plan changes
- Carefully compare the benefits under each option in relation to the premiums to determine which plan best meets your needs
- Verify that your provider(s) will be participating in the option you choose – call the Plan vendor or go the vendor Web site
- Check the distance you will have to drive to see your provider(s)
- Check Preferred Drug Lists to see if your prescriptions are covered and at what co-pay or co-insurance level

- If you have questions about your options, you may call: the CIGNA Retiree Line (800) 942-6724 or the UnitedHealthcare Retiree Line at (877) 755-5343
- If you or your covered spouse or disabled children are turning 65 on or before January 1, 2010, carefully read Section 2 for important information about premiums and your benefit choices
- If you or a covered dependent will become eligible for Medicare during 2010, carefully read Section 2

How Can I Make My Health Insurance Election?

- You may make your election online. See the instructions below OR you may complete your Personalized Change Form (PCF) and mail the form in the enclosed envelope to the State Health Benefit Plan, P.O. Box 1990, Atlanta, GA 30301-1990
- Your envelope must be postmarked by November 10, 2009 for your election to be valid. Any forms postmarked after November 10, 2009 will not be processed (NO EXCEPTIONS)
- If you make an election online **do not** complete the PCF

Important Reminders

- The election you make during the ROCP is valid for the 2010 Plan Year unless you experience a qualifying event which allows you to change options
- Be sure your address is kept current. All retiree communications from SHBP are through the United States mail
- You should verify that the correct health deduction is taken from each retirement check if you are receiving an annuity

Follow these Steps to Make Your ROCP Election Online

1. Go to www.oe2010.ga.gov. The Web site is available beginning at 4 a.m. on October 9th
   a) Register the first time you logon, by clicking on "Register"
   b) Enter your policy number and date of birth
   c) Create, enter and re-enter the password to confirm (please note what your password is for future reference)
   d) Select a security question and answer it
   e) Complete by clicking "Register"
   f) You are now logged in. If you exit the system, you will be directed to the "login" screen to enter your policy number and the password you chose above
2. After reading the "Terms, Conditions and Instructions," scroll to the end of the text, click on the "I Agree" button

3. Your name and address will display. If needed, make any changes. Place a 'check' in the check box to confirm that you have validated your address
4. You will now see information from Thomson Reuters who manages the SHBP data. This information compares your 2008 medical and prescription claims cost against the 2010 plan options and premium structure. The analysis will show which SHBP option for 2010 is expected to have the lowest cost based on the 2008 claims experience
5. The dependents screen will appear. Indicate 'Yes' or 'No' for each dependent to be covered. **If you mark "No" next to all your dependents, you will be changed to single coverage and your dependents will no longer be eligible for coverage**
6. Review your Medicare information (if available) on the Coverage Selection page. Select your health benefit coverage option
7. A considerations page will be displayed. Please read this page carefully as it is designed to assist you with items you may wish to consider before confirming your election. If you wish to change your election after reviewing this page, click on the "Return" button to go back to the Coverage Selection page. If you are satisfied with your election, click on the "Confirm" button
8. A Pre-Confirmation page will be displayed. Review your health benefit election, listed dependents and check your answers to the surcharge questions. If your election is not correct, make any corrections through the edit function. Click 'Confirm' to finalize your election
9. This is your confirmation page, which reflects your 2010 benefit election. Click 'Printer Friendly' to produce an easy to print version of your confirmation page, which will include a confirmation number. You may also save your confirmation on your computer or to a disk by saving the printer friendly confirmation as a pdf file. This confirmation page is your record of your election. Each time you login to the system and confirm your choices, you will receive a unique confirmation number which you should print or save. The benefits elected and confirmed as of 4:30 p.m. on November 10, 2009 will be your benefit election for the 2010 Plan Year

NOTE: If a confirmation number does not show, you have not completed the process. You must click "Confirm" to complete your election. If you are unable to print or save this page, copy the confirmation number and keep it in a safe place

10. Click on "Logout" to exit
11. **Do not wait until the last minute** to go online to make your election for 2010 as Web traffic may be heavy and exceptions will not be allowed if you were unable to complete your 2010 election. *REMINDER: the Web site will close at 4:30 p.m. EST on November 10, 2009*

If you are unable to access www.oe2010.ga.gov to make your ROCP election, contact SHBP for assistance at (800) 610-1863 or (404) 656-6322 prior to the close of ROCP.

Understanding Your Plan Options

Health Reimbursement Arrangement (HRA)

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

Plan Features

- The plan offers unlimited wellness benefits based on age and gender national guidelines when seeing in-network providers only
- HRA dollar credits are part of this option only and can only be used with the HRA option
- The amount in your HRA is used to reduce the deductible and maximum out-of-pocket
- There is not a separate deductible and out-of-pocket maximum for out-of-network expenses

After satisfying your deductible, you will pay your coinsurance amount until you reach your out-of-pocket maximum

- Certain drug costs are waived if SHBP is primary and you participate in one of the Disease State Management Programs (DSM) for Diabetes, Asthma and/or Coronary Artery Disease

High Deductible Health Plan (HDHP)

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

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

Considerations:

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

Open Access Plans (OAP)

Just like a PPO, these options allow you to receive benefits from in-network and out-of-network providers, and provides access on a statewide and national basis across the United States. To receive the highest level of benefit coverage and to avoid filing claims and balance billing, you should use an in-network provider. If you use an out-of-network provider, the reimbursement will be lower and you will be subject to balance billing from your provider.

Plan Features

- You do not have to select a primary care physician (PCP) or obtain a referral to see a specialist; however, you are encouraged to select a PCP to help coordinate your care
- You must satisfy a separate in-network and out-of-network deductible and separate out-of-pocket maximum
- Out-of-network benefits are subject to balance billing (the amount above the negotiated rate approved by the vendor)
- Co-payments do not apply toward deductibles or out-of-pocket maximum unless otherwise noted

Health Maintenance Organization (HMO)

A HMO allows you to obtain benefits from participating providers only and does not require you to select a Primary Care Physician (PCP). HMOs provide 100 percent benefit coverage for preventive health care needs after paying applicable co-payments. Certain services are subject to a deductible and co-insurance. *See pages 14–21 for more information.*

Plan Features

- Both CIGNA and UnitedHealthcare provide a national network and services are paid at the same benefit levels when using network providers outside of Georgia
- You do not have to obtain a referral to see a specialist; however, you are encouraged to select a PCP to help coordinate your care
- Coverage is available only when using in-network providers (except in cases of emergencies)
- Co-payments do not count toward your deductible or out-of-pocket maximum

having a baby? adopting a child? getting married or divorced?

Remember you must contact SHBP within 31 days from the qualifying event to add dependents.

Health Savings Account (HSA) – Information Only

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

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

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

HRA and HSA Considerations

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

Benefits Comparison: OAP – HRA – HDHP – HMO

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

	OPEN ACCESS OPTION		HRA OPTION	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Covered Services	*The Plan Pays:*		*The Plan Pays:*	
Maximum Lifetime Benefit (combined for all SHBP Options)	$2 million		$2 million	
Pre-Existing Conditions (First year in Plan only, subject to HIPAA)	$1,000		Not applicable	
Lifetime Benefit Limit for Treatment of: (combined for Open Access Option and HDHP) • Temporomandibular joint dysfunction (TMJ)	$1,100		$1,100	
Deductible/Co-Payments: • Retiree • Family • Hospital deductible per admission for Medical and Behavioral Health	$600 $1,800 $250	$1,200 $3,600	$1,100* $2,750* Not applicable **HRA credits will reduce this amount.*	
Out-of-Pocket Maximum: • Retiree • Family	$2,000 + co-pays $4,000 + co-pays	$4,000 + co-pays $8,000 + co-pays	$2,500* $5,700* **HRA credits will reduce this amount.*	
HRA Credits: • Retiree • Family	None		$500 $1,500	
Physicians' Services				
Primary Care Physician or Specialist Office or Clinic Visits: Treatment of illness or injury	$35 per office visit co-payment; subject to deductible for associated lab and x-ray	60% coverage; subject to deductible	85% coverage; subject to deductible	60% coverage; subject to deductible
Primary Care Physician or Specialist Office or Clinic Visits for the Following: • Wellness care/preventive health care • Annual gynecological exams (these services are not subject to the deductible)	$35 co-payment per office visit; No co-payment for associated tests and immunizations. Maximum of $1000 per person per Plan Year	Not covered. Charges do not apply to deductible or annual out-of-pocket limits	100% coverage; not subject to deductible	Not covered. Charges do not apply to deductible or annual out-of-pocket limits

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

HIGH DEDUCTIBLE OPTION (HDHP)		HMO OPTIONS
In-Network	Out-of-Network	In-Network
The Plan Pays:		*The Plan Pays:*
$2 million		$2 million
Not applicable		Not applicable
$1,100		No separate lifetime benefit limit
$1,200 $2,400	$2,400 $4,800	$600 $1200
Not applicable		Not applicable
$1,800 $3,100	$4,000 $7,400	$2,000 + co-pays $4,000 + co-pays
None		None
90% coverage; subject to deductible	60% coverage; subject to deductible	$35 per office visit co-payment
100% coverage; not subject to deductible	Not covered; Charges do not apply to deductible or annual out-of-pocket limits	100% after a per visit co-payment of $35 for primary care and specialty care; No co-payment for immunizations and mammograms

Chart continued pg. 16

	OPEN ACCESS OPTION		HRA OPTION	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Physicians' Services	*The Plan Pays:*		*The Plan Pays:*	
Maternity Care (prenatal, delivery and postpartum)	80% coverage; not subject to deductible after initial $35 co-payment	60% coverage; subject to deductible	85% coverage; subject to deductible	60% coverage; subject to deductible
Physician Services Furnished in a Hospital • Visits; surgery in general, including charges by surgeon, anesthesiologist, pathologist and radiologist	80% coverage; subject to deductible	60% coverage; subject to deductible	85% coverage; subject to deductible	60% coverage; subject to deductible
Physician Services for Emergency Care Non-emergency use of the emergency room not covered	80% coverage; subject to in-network deductible		80% coverage; subject to in-network deductible	
Outpatient Surgery— • When billed as office visit	80% coverage; subject to deductible	60% coverage; subject to deductible	85% coverage; subject to deductible	60% coverage; subject to deductible
• When billed as outpatient surgery at a facility	80% coverage; subject to deductible	60% coverage; subject to deductible	85% coverage; subject to deductible	60% coverage; subject to deductible
Allergy Shots and Serum	100% for shots and serum; $35 per visit co-payment not subject to deductible (no co-payment if office visit not billed)	60% coverage; subject to deductible	85% coverage; subject to deductible	60% coverage; subject to deductible
Hospital Services				
Inpatient Services • Inpatient care, delivery and inpatient short-term acute rehabilitation services	80% coverage after deductible; and subject to a $250 per admission deductible	60% coverage after deductible; and subject to a $250 per admission deductible	85% coverage; subject to deductible	60% coverage; subject to deductible
• Well-newborn care	100% coverage; not subject to deductible	60% coverage; subject to deductible	85% coverage; subject to deductible	60% coverage; subject to deductible
Outpatient Surgery— Hospital/facility	80% coverage; subject to deductible	60% coverage; subject to deductible	85% coverage; subject to deductible	60% coverage; subject to deductible
Emergency Care—Hospital • Treatment of an emergency medical condition or injury • Non-emergency use of the emergency room not covered	80% coverage after $150 per visit co-payment; co-payment waived if admitted; subject to in-network deductible		85% coverage; subject to deductible	

HIGH DEDUCTIBLE OPTION (HDHP)		HMO OPTIONS
In-Network	Out-of-Network	In-Network
The Plan Pays:		*The Plan Pays:*
90% coverage; subject to deductible	60% coverage; subject to deductible	100% after initial $35 co-payment
90% coverage; subject to deductible	60% coverage; subject to deductible	80% coverage; subject to deductible
90% coverage; subject to in-network deductible		100% ($150 co-pay applies to facility expenses)
90% coverage; subject to deductible	60% coverage; subject to deductible	100% after $35 co-payment if billed as office visit
90% coverage; subject to deductible	60% coverage; subject to deductible	80% coverage; subject to deductible
90% coverage; subject to deductible	60% coverage; subject to deductible	100% for shots and serum after a $35 per visit co-payment; No co-pay if office visit not billed
90% coverage; subject to deductible	60% coverage; subject to deductible	80% coverage; subject to deductible
90% coverage; subject to deductible	60% coverage; subject to deductible	100% coverage not subject to deductible
90% coverage; subject to deductible	60% coverage; subject to deductible	80% coverage; subject to deductible
90% coverage; subject to in-network deductible		100% after a $150 per visit co-payment; if admitted co-payment waived; subject to deductible

Chart continued pg. 18

	OPEN ACCESS OPTION		HRA OPTION	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Outpatient Testing, Lab, etc.	*The Plan Pays:*		*The Plan Pays:*	
Non Routine Laboratory; X-Rays; Diagnostic Tests; Injections—including medications covered under medical benefits—for the treatment of an illness or injury	80% coverage; subject to deductible	60% coverage; subject to deductible	85% coverage; subject to deductible	60% coverage; subject to deductible
Behavioral Health				
Mental Health and Substance Abuse Inpatient Facility and Partial Day Hospitalization NOTE: Contact vendor regarding prior authorization.	80% coverage; subject to deductible	60% coverage; subject to deductible	85% coverage; subject to deductible	60% coverage; subject to deductible
Mental Health and Substance Abuse Outpatient Visits and Intensive Outpatient NOTE: Contact vendor regarding prior authorization.	80% coverage; subject to deductible	60% coverage; subject to deductible	85% coverage; subject to deductible	60% coverage; subject to deductible
Dental				
Dental and Oral Care NOTE: Coverage for most procedures for the prompt repair of sound natural teeth or tissue for the correction of damage caused by traumatic injury.	80% coverage; subject to deductible	60% coverage; subject to deductible	85% coverage; subject to deductible	60% coverage; subject to deductible
	NOTE: Notification required for all UHC options.			
Temporomandibular Joint Syndrome (TMJ) NOTE: Coverage for diagnostic testing and non-surgical treatment up to $1,100 per person lifetime maximum benefit. This limit does not apply to the HMO.	80% coverage; subject to deductible	60% coverage; subject to deductible	85% coverage; subject to deductible	60% coverage; subject to deductible
Vision				
Routine Eye Exam NOTE: Limited to one eye exam every 24 months.	80% coverage; not subject to deductible	Eye exam not covered	100% coverage; not subject to deductible	Eye exam not covered
Other Coverage				
Hearing Services Routine hearing exam	Not covered		85% coverage for routine exam and fitting; subject to deductible. $1,500 hearing aid allowance every 5 years; not subject to the deductible	
Ambulance Services for Emergency Care NOTE: "Land or air ambulance" to nearest facility to treat the condition.	80% coverage; subject to in-network deductible		85% coverage; subject to in-network deductible	
Urgent Care Services NOTE: All subject to deductible except HMO.	80% coverage after a $45 per visit co-payment	60% coverage	85% coverage; subject to deductible	60% coverage; subject to deductible

HIGH DEDUCTIBLE OPTION (HDHP)		HMO OPTIONS
In-Network	Out-of-Network	In-Network
The Plan Pays:		*The Plan Pays:*
90% coverage; subject to deductible	60% coverage; subject to deductible	80% coverage; subject to deductible
90% coverage; subject to deductible	60% coverage; subject to deductible	80% coverage; not subject to deductible
90% coverage; subject to deductible	60% coverage; subject to deductible	100% after $35 per visit co-payment. $10 co-payment for group therapy
90% coverage; subject to deductible	60% coverage; subject to deductible	100% after $35 per visit co-payment; if inpatient/ outpatient facility, 80% subject to deductible
NOTE: Notification required for all UHC options.		
90% coverage; subject to deductible	60% coverage; subject to deductible	100% after $35 co-payment for related surgery and diagnostic services; excludes appliances and orthodontic treatment; if inpatient/ outpatient facility, 80% subject to deductible
100% coverage; not subject to deductible	Eye exam not covered	100% after $35 co-payment; not subject to deductible. $200 annual benefit for glasses and contacts
90% coverage for route exam and fitting; subject to deductible. $1,500 hearing aid allowance every 5 years; not subject to the deductible		Not covered
90% coverage; subject to in-network deductible		100% coverage; not subject to deductible
90% coverage; subject to deductible	60% coverage; subject to deductible	100% after $35 co-payment

Chart continued pg. 20

	OPEN ACCESS OPTION		HRA OPTION	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Other Coverage	*The Plan Pays:*		*The Plan Pays:*	
Home Health Care Services NOTE: Prior approval required.	80% coverage; subject to deductible	60% coverage; subject to deductible	85% coverage; subject to deductible	60% coverage; subject to deductible
Skilled Nursing Facility Services NOTE: Prior approval required.	80% coverage after deductible; up to 120 days per Plan Year; subject to a $250 per admission deductible	Not covered	85% coverage; up to 120 days per Plan Year; subject to deductible	Not covered
Hospice Care NOTE: Prior approval required.	100% coverage; subject to deductible	60% coverage; subject to deductible	85% coverage; subject to deductible	60% coverage; subject to deductible
Durable Medical Equipment (DME)—Rental or purchase NOTE: Prior approval required for certain DME.	80% coverage; subject to deductible	60% coverage; subject to deductible	85% coverage; subject to deductible	60% coverage; subject to deductible
Outpatient Acute Short-Term Rehabilitation Services • **Physical Therapy** • **Speech Therapy** • **Occupational Therapy** • **Other short term rehabilitative services**	80% coverage; subject to deductible; $20 per visit co-payment up to 40 visits per Plan Year (not to exceed a total of 40 visits combined, including any out-of-network visits)	60% coverage; subject to deductible; up to 40 visits per Plan Year (not to exceed a total of 40 visits, including any in-network visits)	85% coverage; subject to deductible; up to 40 visits per Plan Year (not to exceed a total of 40 visits combined, including any out-of-network visits)	60% coverage; subject to deductible; up to 40 visits per Plan Year (not to exceed a total of 40 visits combined, including any in-network visits)
Chiropractic Care NOTE: Coverage for up to a maximum of 20 visits per Plan Year.	80% coverage; after a $35 per visit co-payment; not subject to deductible	60% coverage; subject to deductible	85% coverage; subject to deductible	60% coverage; subject to deductible
Foot Care	80% coverage; after a $35 per visit co-payment; not subject to deductible	60% coverage; subject to deductible	85% coverage; subject to deductible	60% coverage; subject to deductible
Transplant Services NOTE: Prior approval required.	80% coverage at contracted transplant facility; subject to deductible and $250 per admission deductible	Not covered	85% coverage; subject to deductible	60% coverage; subject to deductible
Pharmacy – You Pay				
Tier 1 Co-payment NOTE: No Tiers in HRA Option	$15	$15*	15% generic; 25% brand; subject to deductible	40% generic; 40% brand; subject to deductible*
Tier 2 Co-payment	$40	$40*	Not applicable	Not applicable
Tier 3 Co-payment	$100	$100*	Not applicable	Not applicable
Tier 4 Co-payment	Not applicable	Not applicable	Not applicable	Not applicable

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

HIGH DEDUCTIBLE OPTION (HDHP)		HMO OPTIONS
In-Network	Out-of-Network	In-Network
The Plan Pays:		*The Plan Pays:*
90% coverage; subject to deductible	60% coverage; subject to deductible	100% coverage; up to 120 visits per Plan Year
90% coverage up to 120 days per Plan Year; subject to deductible	Not covered	80% coverage; up to 120 days per Plan Year; subject to deductible
90% coverage; subject to deductible	60% coverage; subject to deductible	100% coverage; subject to deductible
90% coverage; subject to deductible	60% coverage; subject to deductible	100% coverage when medically necessary
90% coverage up to 40 visits per therapy per Plan Year; subject to deductible (not to exceed a total of 40 visits combined, including any out-of-network visits)	60% coverage up to 40 visits per therapy per Plan Year; subject to deductible (not to exceed a total of 40 visits combined, including any in-network visits)	100% coverage after $25 per visit co-payment; up to 40 visits per therapy per Plan Year
90% coverage; subject to deductible	60% coverage; subject to deductible	100% coverage after $35 co-payment per visit
90% coverage; subject to deductible	60% coverage; subject to deductible	80% coverage after $35 co-payment per visit
90% coverage at contracted transplant facility; subject to deductible	Not covered	80% coverage; subject to deductible
20% coverage; subject to deductible $10 min./$100 max.	Not covered	$15
20% coverage; subject to deductible $10 min./$100 max.	Not covered	$40
20% coverage; subject to deductible $10 min./$100 max.	Not covered	$75
Not applicable	Not covered	Not covered

SECTION 2

MEDICARE ELIGIBLE RETIREES/ DEPENDENTS

If you, your spouse or dependents have Medicare because of age or disability you should carefully read Section 2 to understand the changes in options and premiums.

- Law requires that SHBP pay benefits after Medicare has paid
- You should enroll in Medicare Parts A and B when you first become eligible so that you may enroll in one of the SHBP Medicare Advantage options
- SHBP will pay primary benefits on members not enrolled in Medicare but you will no longer receive the state contribution toward your premiums. You will pay the entire cost of the coverage but will receive a credit for each Part of Medicare you have
- Members who are enrolled in Medicare due to End Stage Renal Disease (ESRD) will need to contact the Social Security Administration to determine when Medicare becomes primary
- Medicare information is available at:
    - www.cms.hhs.gov
    - www.medicare.gov
    - www.ssa.gov
    - 1-800-669-8387 (Georgia Cares) for Part D Prescription Drug Coverage
    - 1-800-633-4227 (Medicare)

new telephonic enrollment:

Enroll in a Medicare Advantage Plan by phone:

CIGNA– 800-942-6724

UnitedHealthcare– 877-755-5343

Plan Changes

- **Retirees and or their spouses with Medicare coverage must enroll in one of the four SHBP Medicare Advantage options to continue to receive the state contribution to the total cost of your health care**
- The SHBP Medicare Advantage Plan currently offered in 2009 will have a name change to the Medicare Advantage Standard Plan
- A New SHBP Medicare Advantage Premium Plan with enriched benefits and lower out-of-pocket costs will also be offered
- Retirees or their covered dependents who are not eligible for the SHBP Medicare Advantage option because they never enrolled in Medicare Part B will be able to enroll in the HRA, HDHP, Open Access or HMO options from the same vendor
- Retirees and/or their spouses with Medicare coverage, or who are eligible for Medicare Part B but did not enroll, may enroll in the HRA, HDHP, Open Access or HMO options but will pay the entire cost for the coverage
- Telephonic enrollment for those enrolling in the SHBP Medicare Advantage Options. You no longer have to go online or complete and mail a personalized change form to SHBP to make your election

What are My 2010 SHBP Plan Options if I Want to Keep the State Contribution?

- **CIGNA Standard Medicare Access Plus Rx**
- **CIGNA Premium Medicare Access Plus Rx**
- **UnitedHealthcare® MedicareDirect™ Standard plan**
- **UnitedHealthcare® MedicareDirect™ Premium plan**

What is a Medicare Advantage with Prescription Drugs (MAPD) Private Fee-for-Service (PFFS) Plan Option?

A Medicare Advantage with Prescription Drugs (MAPD) Private-Fee-for-Service (PFFS), product is an approved plan by the Centers for Medicare & Medicaid Services (CMS) and sometimes called a Medicare Part C Plan. This plan is generally for retirees and their eligible dependents enrolled in Medicare Parts A and B but SHBP has expanded the Medicare Advantage coverage to include those who do not have Part A. This option takes the place of your original Medicare (Part A-Hospital and Part B-Medical Insurance Benefits) and includes a Medicare Part D prescription drug benefit.

This option offers nationwide coverage where members may see any provider willing to accept the Plan's (CIGNA or UnitedHealthcare) terms, conditions and payment rates. This option provides great flexibility in terms of accessibility to medical providers and includes coverage for prescription drugs through the plan's national pharmacy networks.

Currently in 2009, SHBP only offers one Medicare Advantage Plan Option offered through CIGNA and UnitedHealthcare. This option will be offered in 2010 and will be called the SHBP MAPD PFFS Standard Plan. The SHBP MAPD PFFS Premium option is a new plan offered by SHBP. Both plans are custom plans with enriched benefits and are structured to reduce/limit retirees' out-of-pocket expenses.

Enrollment in any of the SHBP Medicare Advantage options is subject to CMS approval. CMS requires the correct address and Medicare number of all enrollees; so it is important that SHBP's records are correct when provided to CMS.

Medicare Advantage requirement:

Eligibility for Medicare Advantage Plans requires that you have Medicare Part B. Part D is part of the Medicare Advantage Plan so you don't need a separate Part D plan.

SHBP tip:

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

How Does the SHBP MAPD PFFS Plan Option Work (Medical)?

- You choose any "Deemed" Provider (a provider who is eligible to receive payment from Medicare and who agrees to the CIGNA Medicare Access Plus Rx or UnitedHealthcare Medicare Direct terms, conditions and payment rate)
- Show your insurance card
- Pay any applicable co-pay

What is a Deemed Provider and What Does it Have to do with Receiving Care?

- Your doctor must be eligible to receive payment from Medicare and agree to accept the terms and conditions of the plan you are enrolled in. He/she will then be considered a Deemed Provider
- If your doctor or hospital does not agree to be a Deemed Provider, any services received will not be covered (except in cases of emergency)
- If your doctor wants to become a Deemed Provider, you or your physician can contact CIGNA or UnitedHealthcare directly
- Your provider will file your claims for you

What About Coverage for My Prescription Drugs Under these Plans?

- Most Medicare Part D plans have a deductible and what is called a coverage gap commonly referred to as the "doughnut hole." SHBP has waived the deductible and will provide a benefit through the coverage gap for you. You will only pay your co-pay amount until you reach the plan's predetermined limit of $4550
- Once you reach the limit you will pay the greater of 5 percent coinsurance or reduced co-pays for generics and brand drugs ($2.50–$6.30) for the remainder of the calendar year

health tip:

Regular exercise can help direct your attention away from daily stress and may contribute to a feeling of mental well being.

Considerations:

- Must have Medicare Parts A and B or at least Part B to enroll in a Medicare Advantage Option
- Prescription drugs are included; you do not need to purchase a separate Part D plan
- If you enroll in a Medicare Advantage plan through SHBP your Part D coverage will automatically be dropped by CMS
- Must seek services from a "Deemed" provider that accepts CIGNA or UnitedHealthcare's terms, conditions and payment rates
- No filing of claims with Medicare
- Should you drop your SHBP Medicare Advantage coverage during the year, your original Medicare will automatically go into effect again. You will have a special enrollment period of 63 days from the date coverage was lost to elect a Medicare Part D Plan without penalties applying **BUT YOUR SHBP COVERAGE IS PERMANENTLY GONE**
- Remember your election is for the entire 2010 Plan Year of January 1 – December 31, 2010
- If you enroll in a Medicare Part D Plan after enrolling in a SHBP Medicare Advantage, you will lose your SHBP coverage permanently
- You cannot be enrolled in a **supplemental** Medicare Advantage plan and have Medicare Advantage coverage under a group plan at the same time
- Once you enroll in a SHBP sponsored Medicare Advantage Plan, if you enroll in a supplemental Medicare Advantage plan, you will lose your Medicare Advantage coverage under SHBP (this means you will no longer have coverage under SHBP) and will not be able to get your coverage back
- The only time you can change your SHBP option is during the ROCP
- Retirees can drop SHBP coverage at any time, but may not re-enroll at a later date
- You may change to single coverage at any time

What Happens if One of My Prescription Drugs Isn't Covered Under One of the Medicare Advantage Options?

- If you are taking a medication that may require a change (for instance it is not on the approved CIGNA or UnitedHealthcare's drug list) you will receive a letter after you receive your first supply of that medication. The letter will tell you what to do and the time period that you have to make a change. After that date, you will be required to change to an alternative medication or complete the necessary steps with your doctor to continue your current medication
- You should talk to your doctor and discuss if you should switch to a drug that is covered under your Plan option or request an exception so that the drug you take will be covered
- You can request an exception by contacting your doctor for a statement supporting your request and submitting to CIGNA or UnitedHealthcare for review and approval

What are the Eligibility Requirements to Participate in this Plan?

- Each individual enrolling in this plan must have Medicare A and B or at least Medicare Part B. This means that you or your dependents may enroll even if everyone is not eligible
- The CMS must verify and approve your eligibility

What if I or My Spouse Have Medicare Part A But Are Not Enrolled in Medicare Part B?

- You are not eligible to enroll in the SHBP MAPD PFFS Options
- You may enroll for Medicare Part B during the Medicare annual enrollment period from January 1–March 31 and will pay the monthly Part B premium to Medicare
- Part B coverage will then become effective on July 1 of the same year and you may request to enroll in one of the Medicare Advantage options at the same time
- You will be responsible for paying any late penalties imposed by Medicare
- After enrolling in Medicare Part B, you will have 31 days to enroll in one of the Medicare Advantage plans. Contact your health plan for information on how to enroll in one of the Medicare Advantage Plans offered by SHBP

What if Everyone Covered by My Plan Doesn't Have Medicare?

- When everyone you cover is not eligible to participate in the MAPD PFFS Options, we call this Split Eligibility. This means that the individual with Medicare enrolls in the MAPD PFFS and any family members that have not yet reached eligibility for Medicare (because of age or not being disabled) can enroll in one of the other options offered by SHBP with the same vendor

This is Confusing – What Are Some Examples?

- Dan is the SHBP retiree with family coverage. Dan has Medicare Part A and B and his spouse, Jean does not. Dan can enroll in one of the MAPD PFFS options and Jean in one of the other SHBP options with the same vendor
- Sam is the SHBP retiree with family coverage. His spouse, Mary, has Medicare Parts A and B and Sam doesn't. Mary can enroll in one of the MAPD PFFS options and Sam can enroll in one of the other SHBP options offered with the same vendor
- Rob and his wife Hazel both have Medicare Parts A and B but have two children in college. Rob and Hazel can choose the same Medicare Advantage option and the two children can enroll in another SHBP option offered with the same vendor

Can I and My Spouse Elect Separate Medicare Advantage Plans?

- Peter is the SHBP retiree with family coverage and goes to the doctor every month and wants to enroll in the MAPD PFFS Premium Plan. His wife, Susan goes once a year for her annual physical and wants to enroll in the MAPD PFFS Standard Plan. Can they each make a separate election? No; both the retiree and spouse must enroll in the same Medicare Advantage option

What Does it Mean that the MAPD PFFS Plan Replaces My Original Medicare Coverage?

- CIGNA and UnitedHealthcare are licensed by the CMS to offer the SHBP Medicare Advantage Plans
- These plans combine Medicare Parts A, B and D and benefits under SHBP
- One claim is submitted to the health care vendor and one check is sent to the provider
- Since benefits under Medicare and SHBP are combined, coordination of benefits is not necessary
- You will no longer have to submit claims to Medicare and then to SHBP
- There will be only one explanation of benefits (EOB)
- You only present your Medicare Advantage ID card when you go to the doctor

IMPORTANT NOTE:

CMS will cancel coverage in the SHBP Medicare Advantage Plan if a later request is made for enrollment in a Medicare Advantage supplemental plan or Medicare Part D plan

Does CMS Check Eligibility for Coverage under These Plans? YES

- CMS maintains eligibility and enrollment for all Parts of Medicare Coverage – A, B, C and D
- SHBP submits each request for enrollment to CMS for verification of eligibility
- CMS approves or denies eligibility and notifies SHBP of the effective date of coverage
- CMS will automatically disenroll you from Medicare Part D when your Medicare Advantage eligibility is approved

What if I Currently Am Enrolled in an HRA and Will Have Dollars Left at the End of the Year?

If you will have a balance of $10 or more, SHBP will set you up with an individual HRA account under the SHBP Medicare Advantage options. This account can be used to pay your co-pays, co-insurance, etc. until the funds are exhausted. If your spouse stays enrolled in the HRA, the account will not move until your spouse moves to the Medicare Advantage option.

What are My SHBP Options with No State Contributions?

- You have the same options as active employees to select from
- See pages 14–21 of this Retiree Guide to review these options
- You will pay the entire cost for the option you select
- You may obtain the rate by visiting the Web site at: www.dch.georgia.gov/shbp or by referencing the enclosed rate sheet
- SHBP will allow a change to a Medicare Advantage option after January 1, 2010, subject to CMS approval

Benefits Comparison: SHBP Medicare Advantage with Prescription Drugs (MAPD) Private Fee-for-Service (PFFS) Standard and Premium Plans

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

	Standard SHBP MAPD PFFS CIGNA, UnitedHealthcare	Premium SHBP MAPD PFFS CIGNA, UnitedHealthcare
Covered Services	*The Plan Pays:*	*The Plan Pays:*
Maximum Lifetime Benefit (combined for all SHBP Options)	Not applicable	Not applicable
Pre-Existing Conditions (First year in Plan only, subject to HIPAA)	Not applicable	Not applicable
Lifetime Benefit Limit for Treatment of • Temporomandibular joint dysfunction (TMJ)	Contact plans for details	Contact plans for details
Deductibles • Retiree • Family	Not applicable Not applicable	Not applicable Not applicable
Out-of-Pocket Maximum • Retiree • Family	$1000 per member	$500 per member
Physicians' Services		
Primary Care Physician or Specialist Office or Clinic Visits Treatment of illness or injury	Primary—$20 per office visit co-payment; Specialist—$25 per office visit co-payment	Primary—$10 per office visit co-payment; Specialist—$20 per office visit co-payment
Primary Care Physician or Specialist Office or Clinic Visits Annual routine physical exam (non-Medicare covered)	Primary—$20 per office visit co-payment; Specialist—$25 per office visit co-payment	Primary—$10 per office visit co-payment; Specialist—$20 per office visit co-payment
Annual Screenings	0% co-payment; Office visit co-pay may apply (mammograms, pap smears, prostate cancer screening, cholesterol)	0% co-payment; office visit co-pay may apply
Inpatient Hospital Services	$190 co-payment per day for days 1-4; $0 co-payment per day for days 5 and beyond	$100 co-payment per day for days 1-3; $0 co-payment per day for days 4 and beyond
Outpatient Hospital Services (includes observation, medical and surgical care)	$95 co-payment per surgery	$50 co-payment per surgery

	Standard SHBP MAPD PFFS CIGNA, UnitedHealthcare	Premium SHBP MAPD PFFS CIGNA, UnitedHealthcare
Behavioral Health	*The Plan Pays:*	*The Plan Pays:*
Mental Health and Substance Abuse Inpatient Facility and Partial Day Hospitalization NOTE: Mental Health lifetime max does not apply when admitted to a psychiatric unit of a general hospital.	$190 co-payment per day for days 1–4, $0 co-payment for days 5–190; 190 day lifetime maximum when admitted to a psychiatric hospital; $60 co-payment per day for partial hospitalization	$100 co-payment per day for days 1–3, $0 co-payment for days 4–190; 190 day lifetime maximum when admitted to a psychiatric hospital; $50 co-payment per day for partial hospitalization
Mental Health and Substance Abuse Outpatient Visits	$25 per office visit co-payment	$10 per office visit co-payment
Dental		
Dental and Oral Care Medicare covered	$25 per office visit co-payment for Medicare covered dental services	$20 per office visit co-payment for Medicare covered dental services
Vision		
Routine Eye Exam NOTE: Limited to one eye exam every 12 months.	$25 co-payment per office visit—limited to 1 annual eye exam; $125 eyewear (glasses or contact lenses and frames) allowance every 24 months	$20 co-payment per office visit—limited to 1 annual eye exam; $125 eyewear (glasses or contact lenses and frames) allowance every 24 months
Other Coverage		
Routine Hearing Services	$25 co-payment limited to 1 test every 12 months; $1000 hearing aid allowance every 48 months	$20 co-payment limited to 1 test every 12 months; $1000 hearing aid allowance every 48 months
Ambulance Services for Emergency Care NOTE: "Land or air ambulance" to nearest facility to treat the condition.	$0 co-payment	$0 co-payment
Urgent Care Services	$25 co-payment waived if admitted to hospital within 24 hours for the same condition	$20 co-payment waived if admitted to hospital within 24 hours for the same condition
Other Coverage		
Home Health Care Services	$0 co-payment per visit	$0 co-payment per visit
Emergency Care	$50 co-payment waived if admitted to hospital within 24 hours for the same condition	$50 co-payment waived if admitted to hospital within 24 hours for the same condition

	Standard SHBP MAPD PFFS CIGNA, UnitedHealthcare	Premium SHBP MAPD PFFS CIGNA, UnitedHealthcare
Other Coverage	*The Plan Pays:*	*The Plan Pays:*
Skilled Nursing Facility Services	$0 co-payment per day for days 1–10; $50 co-payment per day for days 11–100 for up to 100 days per benefit period (no prior hospital stay required)	$0 co-payment per day for days 1–10; $25 co-payment per day for days 11–100 for up to 100 days per benefit period (no prior hospital stay required)
Hospice Care	100% coverage; (must receive care from a Medicare covered hospice facility; no prior approval required)	100% coverage; (must receive care from a Medicare covered hospice facility; no prior approval required)
Durable Medical Equipment (DME)	90% coverage for Medicare covered items (no prior approval required)	90% coverage for Medicare covered items (no prior approval required)
Outpatient Acute Short-Term Rehabilitation Services • **Physical Therapy** • **Speech Therapy** • **Occupational Therapy** • **Other short term rehabilitative services**	$25 co-payment per office visit for Medicare covered services; no limit on number of visits	$10 co-payment per office visit for Medicare covered services; no limit on number of visits
Chiropractic Care	Medicare Covered—$25 co-payment per office visit; Routine Non-Medicare Covered—$25 co-payment per office visit; limit of 20 visits per year	Medicare Covered—$20 co-payment per office visit; Routine Non-Medicare Covered—$20 co-payment per office visit; limit of 20 visits per year
Foot Care	$20 Primary Care—$25 Specialist per office visit co-payment; Routine Non-Medicare Covered—$25 co-payment, limit of 6 visits per year	$10 Primary Care—$20 Specialist per office visit co-payment; Routine Non-Medicare Covered—$20 co-payment; limit of 6 visits per year
Transplant Services NOTE: Prior approval required.	$190 co-payment per day for days 1–4; $0 co-payment per day for days 5 and beyond; Non-Medicare Covered—$25 co-payment; limit of 6 visits per year	$100 co-payment per day for days 1–3; $0 co-payment per day for days 4 and beyond
Pharmacy		
Tier 1 Co-payment	*$10 retail; $20 mail order—90-day supply	*$10 retail; $20 mail order—90-day supply
Tier 2 Co-payment	*$25 retail; $50 mail order—90-day supply	*25% up to max of $25; mail order—25% not to exceed $50
Tier 3 Co-payment	*$50 retail; $100 mail order—90- day supply	*25% up to max of $50; mail order—25% not to exceed $100
Tier 4 Co-payment	*$50 retail; $100 mail order—90-day supply; Medicare Part B Covered Drugs—90% coverage	*25% up to max of $50; mail order—25% not to exceed $100

*After your yearly out-of-pocket costs reach $4550, you pay the greater of $2.50 for the generic or a preferred brand drug that is a multi-source drug and $6.30 for all other drugs, or 5% coinsurance.

What Should I Do Before I Make My 2010 Benefit Election?

If you want to change your health coverage option or discontinue coverage, you will need to take action during this ROCP. If you discontinue coverage, you will not be able to enroll later.

- Evaluate your health care needs
- Kaiser Permanente members must make a selection for a NEW option
- If you are currently enrolled in the SHBP Medicare Advantage Option and do not want to make a change, you do not need to take any action
- Carefully read ALL of the changes in benefits outlined in Section 1 and 2 before you make your decision
- Consider the premiums and benefits under each option
- Confirm that your providers will be participating in the option you select

Important Reminders

- The election you make during the ROCP is valid for the 2010 Plan Year unless you experience a qualifying event which allows you to change options
- If you choose a unsubsidized SHBP option and change your mind, you can enroll in a SHBP Medicare Advantage Plan by contacting your health care vendor
- CMS approves each request for Medicare Advantage coverage and notifies SHBP of the effective date of the change
- Be sure your address is kept current. All retiree communications from SHBP are through the United States mail. Notifying your retirement system of any change in address does not update your SHBP records
- You should verify that the correct health deduction is taken from each retirement check if you are receiving an annuity
- You will need to pay the Medicare Part B premium each month to Social Security

Making Your ROCP Election

Select the Method You Wish to Use to Make Your Election:

- By Telephone for Medicare Advantage (new)
- By Mail (Personalized Change Form)
- Online

Follow these Steps to Make Your ROCP Medicare Advantage Election by Telephone

1. Select the vendor and plan
2. Call – CIGNA 800-942-6724; UnitedHealthcare 877-755-5343

Follow these Steps to Make Your ROCP Election by Mail

1. When you receive the Retiree Packet make your election on your enclosed Personalized Change Form (PCF). This is the form on the reverse side of the address label
2. Sign and date the form
3. Mail to SHBP in the envelope that is included in the Retiree Packet
4. Must be post marked by November 10, 2009

Follow these Steps to Make Your ROCP Election Online

1. Go to www.oe2010.ga.gov
   a) Register the first time you logon, by clicking on "Register"
   b) Enter your policy number and date of birth
   c) Create, enter and re-enter the password to confirm (please note what your password is for future reference)
   d) Select a security question and answer it
   e) Complete by clicking "Register"
   f) You are now logged in. If you exit the system, you will be directed to the "login" screen to enter your policy number and the password you chose above
2. After reading the "Terms, Conditions and Instructions" text, scroll to the end of the text, click on the "I Agree" button
3. Your name and address will display. If needed, make any changes. Place a 'check' in the check box to confirm that you have validated your address
4. The dependents screen will appear. Indicate 'Yes' or 'No' for each dependent to be covered. **If you mark "No" next to all your dependents, you will be changed to single coverage and your dependents will no longer be eligible for coverage**
5. Review your Medicare information (if available) on the Coverage Selection page. Select your health benefit coverage option
6. A considerations page will be displayed. Please read this page carefully as it is designed to assist you with items you may wish to consider before confirming your election. If you wish to change your election after reviewing this page, click on the "Return" button to go back to the Coverage Selection page. If you are satisfied with your election, click on the "Confirm" button

7. A Pre-Confirmation page will be displayed. Review your health benefit election and listed dependents. If your election is not correct, make any corrections through the edit function. Click 'Confirm' to finalize your election
8. This is your confirmation page, which reflects your 2010 benefit election. Click 'Printer Friendly' to produce an easy to print version of your confirmation page, which will include a confirmation number. You may also save your confirmation on your computer or to a disk by saving the printer friendly confirmation as a pdf file. This confirmation page is your record of your election. Each time you login to the system and confirm your choices, you will receive a unique confirmation number which you should print or save. The last benefit election made and confirmed as of 4:30 p.m. on November 10, 2009 will be your benefit election for the 2010 Plan Year

   NOTE: If a confirmation number does not show, you have not completed the process. You must click "Confirm" to complete your election. If you are unable to print or save this page, copy the confirmation number and keep it in a safe place.
9. Click on "Logout" to exit
10. **Do not wait until the last minute** to go online to make your election for 2010 as Web traffic may be heavy and exceptions will not be allowed if you were unable to complete your 2010 election. *REMINDER: the Web site will close at 4:30 p.m. EST on November 10, 2009*

If you are unable to access www.oe2009.ga.gov to make your ROCP election, contact SHBP for assistance at (800) 610-1863 or (404) 656-6322 prior to the close of ROCP.

What Happens if I Don't Make an Election?

- You will retain the same vendor (unless enrolled in Kaiser) you currently have and will automatically be enrolled in their SHBP MAPD PFFS Standard Plan. If you have non-Medicare eligible dependents, they will retain the same vendor (except Kaiser) and option
- If you are currently enrolled in Kaiser HMO or Senior Advantage Plans, you will be automatically be enrolled in the CIGNA Standard Medicare Access Plus Rx option. Any non-Medicare eligible dependents will be enrolled in the CIGNA HRA

Health & Wellness

What Can You Do to Improve Your Health?

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

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

Engage in the Health Management Services: Each vendor offers assistance with health care services including disease management, case management and behavioral health.

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

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

SHBP Eligibility

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

Eligible Dependents Are:

- **Your legally married spouse,** as defined by Georgia Law
- **Your never-married dependent children who are:**

1. **Natural or legally adopted children under age 19**, unless they are eligible for coverage as employees. Children that are legally adopted through the judicial courts become eligible only after they are placed in your physical custody
2. **Stepchildren under age 19 who live with you** at least 180 days per year and for whom you can provide documentation satisfactory to the Plan that they are your dependents
3. **Other children under age 19** if they live with you permanently and legally depend on you for financial support – as long as you have a court order, judgment or other satisfactory proof from a court of competent jurisdiction
4. **Your natural children, legally adopted children or stepchildren** who are physically or mentally disabled prior to reaching age 26, who depend on you for primary support and meet clinical guidelines
5. **Your natural children, legally adopted children, stepchildren or other children ages 19 through 25 from categories 1, 2, or 3 above** who are registered full-time students at accredited secondary schools, colleges, universities or nurse training institutions and, if employed, who are not eligible for a medical benefit plan from their employer. The number of credit hours required for full-time student status is defined by the school in which the child is enrolled

SHBP requires documentation annually from the college or university your student attends verifying he/she is a full-time student.

A change to single coverage is allowed at any time. You may discontinue coverage at any time, but you MAY NOT ENROLL LATER.

health tip:

Eating a low-fat, low-sugar diet with plenty of fruits and vegetables can boost your physical and mental health.

Making Changes When You Have a Qualifying Event

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

Qualifying events include, but are not limited to:

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

Please submit your request, within 31 days of the event to SHBP. Requests should not be held waiting on additional information, such as Social Security Number, marriage or birth certificate.

SHBP will accept dependent verification at anytime during the plan year and coverage will be retroactive to the qualifying event date or first of the Plan Year, whichever is later.

Documentation Confirming Eligibility for Your Spouse or Dependents

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

- **Spouse:** A copy of your certified marriage certificate or a copy of your most recent Federal Tax Return (filed jointly with spouse) including legible signatures for you and your spouse with financial information blacked out
- **Natural or student child:** A copy of the certified birth certificate listing the parents by name or a letter of confirmation of birth for newborns. Birth cards without the parents' names are not acceptable

- For students age 19 through age 25, SHBP requires the child's birth certificate and documentation from the school's registrar's office verifying full-time student status and a completed and signed student status form
- **Stepchild:**
  1. A copy of the certified birth certificate showing your spouse is the natural parent;
  2. A copy of the certified marriage certificate showing the natural parent is your spouse; and
  3. A notarized statement that the dependent lives in your home at least 180 days per year

NOTE: No health claims will be paid until the documentation is received and approved by SHBP.

The member's Social Security Number MUST be written on each document so we can match your dependents to your record. Do not send originals as originals will not be returned.

COBRA Rights – Dependents of Retirees

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

About the Following Notices

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

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

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

Georgia Department of
Community Health

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

October 1, 2009

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

For Plan Year: January 1–December 31, 2010

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

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

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

When Can You Join a Medicare Drug Plan?

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

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

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

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

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

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

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

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

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

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

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

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

For more information about Medicare prescription drug coverage:

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

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

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

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

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

Georgia Department of
Community Health

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

October 1, 2009

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

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

For Plan Year: January 1–December 31, 2010

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

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

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

2. The SHBP has determined that the prescription drug coverage offered by the HDHP Option, is on average for all plan participants, NOT expected to pay out as much as standard Medicare prescription drug coverage pays. Therefore, your coverage is considered Non-Creditable Coverage. **This is important, because most likely, you will get more help with your drug costs if you join a Medicare drug plan, than if you only have prescription drug coverage from the HDHP offered by SHBP. This is also important because it may mean that you may pay a higher premium (a penalty) if you do not join a Medicare drug plan when you first become eligible.**

3. You can keep your current coverage in a CIGNA or UnitedHealthcare HDHP offered by the SHBP. However, because your coverage is non-creditable, you have decisions to make about Medicare prescription drug coverage that may affect how much you pay for that coverage, depending on if and when you join a drug plan. When you make your decision, you should compare your current coverage, including what drugs are covered, with the coverage and cost of the plans offering Medicare prescription drug coverage in your area. *Read this notice carefully as it explains your options.*

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

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

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

When Can You Join a Medicare Drug Plan?

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

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

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

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

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

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

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

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

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

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

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

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

Notes

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

Penalties for Misrepresentation

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

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

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