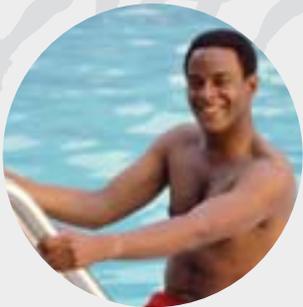
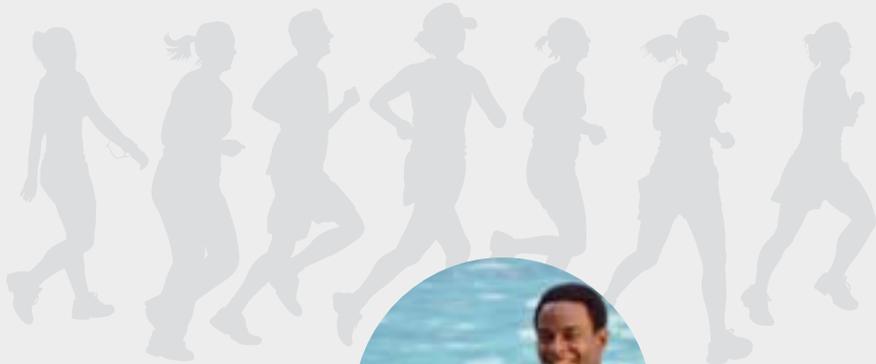


GEORGIA DEPARTMENT OF
COMMUNITY HEALTH



RETIREE



State Health Benefit Plan Decision Guide 2008

RETIREE OPTION CHANGE PERIOD October 10 – November 9, 2007

Phone Numbers/Contact Information

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

Vendor	Member Services	Pharmacy	Web Site
Retiree Help Line	877-246-4190		
UnitedHealthcare			
Definity HRA	800-396-6515		www.myuhc.com/groups/gdch
PPO and Indemnity	877-246-4189 TDD 800-955-8770	877-650-9342	www.myuhc.com/groups/gdch
Choice HMO	866-527-9599 TDD 800-955-8770		www.myuhc.com/groups/gdch
HDHP	877-246-4195 TDD 800-842-5754	877-246-4195	www.myuhc.com/groups/gdch
Blue Cross Blue Shield of GA			
Lumenos HRA	866-835-6863		www.info.lumenos.com
HMO	800-464-1367		www.bcbsga.com
Kaiser Permanente	800-611-1811 TDD 800-255-0056		www.kaiserpermanente.org
Pharmacy		Contact your respective vendor	www.dch.georgia.gov/shbp_plans
All Options: Eligibility	404 656-6322 800 610-1863		www.dch.georgia.gov/shbp_plans
Plan Cost Estimator			www.dch.georgia.gov/shbp_plans
Additional Information			
Medicare	800-633-4227		www.medicare.gov
Centers for Medicare and Medicaid (CMS)			www.cms.gov
Social Security Administration	800-772-1213		www.ssa.gov

Disclaimer: This material 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 2 of this guide contains Plan changes effective January 1, 2008. Prior to the start of the 2008 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, 2008. You may print or request a paper copy by calling the Customer Service number on the back of your ID card. Please keep your Summary Plan Description (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 38342, Atlanta, GA 30334.



GEORGIA DEPARTMENT OF
COMMUNITY HEALTH

Rhonda M. Meadows, MD, Commissioner

Sonny Perdue, Governor

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

October 1, 2007

Dear SHBP Member:

Welcome to 2008 Retiree Option Change Period (ROCP). The ROCP dates will be October 10 – November 9, 2007. Retirees will again make their health election on the Web at www.oe2008.ga.gov.

The State Health Benefit Plan (SHBP) strives to bring the best value to its members. We have heard your feedback and ideas for improvement and are happy to announce two exciting new options that will be offered January 1, 2008.

These options are based on the idea that you should have greater control over how you spend your health care dollars using tools that help you make informed decisions. These new options address two of the largest challenges in our health care system: improving access to affordable, high-quality care and controlling costs.

These consumer driven health plan options with a Health Reimbursement Account (HRA) will be offered by UnitedHealthcare Definity and BlueCross BlueShield of Georgia Lumenos. Each year SHBP will contribute dollars to your HRA for treatment of medical expenses. In 2008, this amount is \$500 for single coverage and \$1,000 for family coverage. If you use up the credits in your HRA account, there is a deductible to meet, and then the plan works very similar to the PPO with co-insurance and in-network and out-of-network benefits. If you have money in your account left over at the end of the year, this is then rolled over to the next year and combined with SHBP's new deposit.

Each plan also provides 100 percent unlimited coverage for wellness care subject to age and gender guidelines. Your wellness expenses are not charged to your HRA.

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

Sincerely,

Rhonda M. Meadows, M.D.

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Welcome to the Retiree Option Change Period (ROCP) for the State Health Benefit Plan for Coverage Effective January 1, 2008 – December 31, 2008

SHBP Acronyms

BCBSGa – BlueCross BlueShield of Georgia
CCO – Consumer Choice Option
DCH – Georgia Department of Community Health
FSA – Flexible Spending Account
HDHP – High Deductible Health Plan
HMO – Health Maintenance Organization
HRA – Health Reimbursement Account
HSA – Health Savings Account
PPO – Preferred Provider Organization
SHBP – State Health Benefit Plan
SPD – Summary Plan Description
UHC – UnitedHealthcare

The ROCP dates are Wednesday, October 10 through Friday, November 9, 2007. This guide will provide you with a brief explanation of each Plan option, important changes in your SHBP options, steps on how to make your ROCP election, information about the health and wellness features available through the health plan options and a comparison of benefits chart. This guide, the *Retiree Decision Guide*, can also be found at www.dch.georgia.gov/shbp_plans or www.oe2008.ga.gov.

Retirees will make their health election at www.oe2008.ga.gov and the Web site will be open beginning 12:01 a.m. on October 10 and will close at 4 p.m. on November 9, 2007.

What's Changing for 2008?

New Offerings

The SHBP will be offering two new consumer driven health plan options statewide through UnitedHealthcare Definity HRA and BlueCross BlueShield of Georgia Lumenos HRA. Advantages of these options are:

- A Health Reimbursement Account (HRA) funded by SHBP that provides first dollar coverage for Single Coverage (\$500) and Family Coverage (\$1,000)
- 100 percent unlimited wellness benefit based on national age and gender guidelines

Wellness Enhancement Expansion

In 2008, SHBP is enhancing its focus on wellness and consumerism. Each retiree and family member is encouraged to take a personal health assessment under the plan option of your choice to evaluate your health risk for certain medical conditions. The SHBP wants you to become a more knowledgeable consumer about your health and well-being. Medical statistics show better outcomes for early detection of identified health issues that are treated before they become more serious. In addition, support tools are available to help you make informed decisions about how you spend your health care dollars.

- The PPO wellness benefit is increasing from \$500 to \$1,000 per covered individual based on national age and gender guidelines
- The HDHP wellness benefit is increasing from \$500 to 100 percent unlimited coverage per covered individual based on national age and gender guidelines

No Longer Offered

- The Indemnity Option will be offered **only** to individuals currently enrolled in this option
- The CIGNA Option will **no longer be offered**. If you do not elect a new option, you and your dependents' coverage will be automatically enrolled in the PPO Option for the 2008 Plan Year. If you file a paper medical claim for services on or before December 31, 2007, the claim must be received by CIGNA at P.O. Box 182223, Chattanooga, TN 37422-7223 no later than March 31, 2008. This requirement also applies to any claim adjustments or appeals. Claims received by CIGNA after March 31, 2008, will not be paid if the services were received in the year 2007 or before. Contact your new vendor for any transition of care issues.
- The TRICARE Supplement will **no longer be offered**. If you do not elect a new option, you and your dependents' coverage will be automatically enrolled in the PPO Option for the 2008 Plan Year. Retiree premiums are based on Medicare coverage at age 65. Please read page 23 for important information

Network Changes

- BlueChoice HMO will be adding Appling, Dade, Dodge, Gordon, Hancock, Stephens, Walker and Webster counties to their service area
- Kaiser Permanente will be adding Carroll, Dawson, Haralson, Heard, Lamar, Meriwether, Pickens and Pike counties to their service area (does not apply to Senior Advantage)

Premiums

For the last 18 months, SHBP members have enjoyed the benefit of a stable premium. However, for the new 2008 Plan Year, premiums will increase by 10 percent. Most large employers have increases of 10 percent or more each year. The SHBP is self-funded, which means that our costs increase as a direct result of our increased claims expenses. While health care costs continue to rise, the SHBP still pays approximately 75 percent of the total cost of your health care benefits.

Eligibility Changes

Services will not be covered for any dependents that have not been verified by SHBP. If you have not yet verified a dependent you wish to cover, SHBP will request documentation verifying the eligibility of your dependent. **Failure to submit the documents within 31 days from SHBP's request will result in the dependent being ineligible for coverage, unless a qualifying event occurs.** *See page 12 for the definition and more information about qualifying events.*

ROCP

SHBP Plan Options

BlueCross BlueShield of Georgia

- *New* – Lumenos with HRA
- BlueChoice HMO

UnitedHealthcare

- *New* – Definity with HRA
- High Deductible Health Plan (HDHP)*
- Preferred Provider Organization (PPO)
- UnitedHealthcare Choice HMO
- Indemnity (if currently enrolled only)

*This option allows you to set up a Health Savings Account. See page 8 for more information.

Kaiser Permanente

- HMO
- Senior Advantage

Each Plan offers a Consumer Choice Option (CCO), which allows you to nominate a provider who is not participating in the network so that benefits may be paid at the in-network rate. See page 11 for more information.

What Should I Do before I Make My 2008 Benefit Election?

If you want to continue with the same coverage you currently have, you don't have to do anything.

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

If you or your covered spouse are turning age 65, please be sure to carefully read the Medicare information on page 23.

- You should carefully review the Retiree Decision Guide to determine which option may best suit your healthcare needs.
- You may contact the Retiree Helpline at 877-246-4190 to obtain rates.
- Call each Plan Option or go to the vendor website to see in which Options your physician or provider participates.
- Check which Tier 1, 2 and 3 co-payments will apply to your prescription drugs on each Plan Option.
- You may make your elections online. See page 5 for instructions OR you may complete your Personalized Change Form (PCF) and mail the form in the enclosed envelope to State Health Benefit Plan, P. O. Box 347069, Atlanta, GA 30334.
- Note your envelope must be postmarked by November 9, 2007 for your SHBP election to be valid. Any forms postmarked after November 9, 2007 will not be processed (note: no exceptions). **DO NOT RETURN THIS FORM IF YOU MAKE YOUR ELECTION ONLINE OR DO NOT CHANGE YOUR BENEFIT ELECTION.**

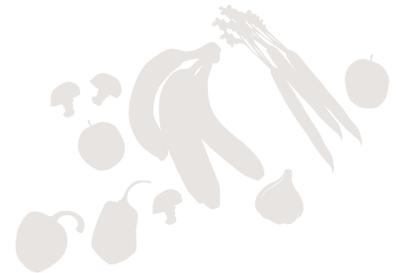
Reminders

- You should submit eligibility verification documents timely for all dependents when requested by SHBP.

- You should verify that the correct health deduction is taken from each retirement check if you receive an annuity.
- Be sure that your address is kept current. All retiree communications from SHBP are through U.S. mail.
- If you are enrolled in Medicare A, B, and D and have not submitted a copy of your card or cards to SHBP, please do so immediately.

Follow These Steps to Make Your ROCP election

- 1) Go to www.oe2008.ga.gov
 - a) Register the first time you logon, by clicking on “Register”
 - b) Enter your policy number and date of birth
 - c) Select, enter and re-enter the password to confirm
 - d) Select a security question and answer it
 - e) Complete by clicking “Register”
2. Now you are on the “login” screen. Re-enter your policy number, password and then click on “Login”
3. After reading the “Terms of Use” text, scroll to the end of the text, click on the “Agree” box, and click “Accept”
4. Your name, address and current coverage tier, and Medicare information will display. If needed, make any changes
5. The dependents screen will appear. Indicate ‘Yes’ or ‘No’ for each dependent to be covered. **If you mark “No” next to all your dependants, you will be changed to single**
6. Select your health benefit coverage option
7. Review your health benefit election, listed dependents on the Pre-confirmation page. If your election is not correct, make any corrections through the edit function. Click ‘Confirm’ to finalize your election
8. Click ‘Printer Friendly’ to produce an easy to print version of your confirmation page, which will include a confirmation number. This reflects your 2008 benefit election. You may also save your confirmation on your computer or to a disk by saving the printer friendly confirmation as a pdf file. 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 p.m. on November 9, 2007 will be your benefit election for the 2008 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. **Do not wait until the last minute** to go online to make your election for 2008 as Web traffic may be heavy and exceptions will not be allowed if you were unable to complete your 2008 election. *REMINDER: the Web site will close at 4 p.m. EST on November 9, 2007*



health tip:

Eat a diet rich in vegetables, fruits, whole grains and fiber. Limit your salt intake.

What Happens if I Don't Go Online or return the PCF to SHBP?

You will retain the same coverage option and tier (single or family) you currently have unless you are enrolled in the CIGNA, CIGNA CCO, or the TRICARE Supplement. If you do not go online or complete the PCF to make a new health election, you will automatically be enrolled in the PPO Option effective January 1, 2008.

Health & Wellness

The health plans offer education on healthy living initiatives. The goal is to provide enhanced information, tools, and support to promote your healthy lifestyle and meet your health care needs. Please refer to your health Plan option for details on programs offered.

- **Personal Health Assessments** – each vendor has a personal health assessment questionnaire available on their Web site that you can complete. This information is kept confidential and will indicate potential health risks. The vendor may contact you regarding steps you can take to control or eliminate this risk or tests you may want to consider
- **Health Management Services** – each vendor offers assistance with health care services such as disease management, case management and behavioral health. Please refer to your health plan option for additional details on programs offered
- **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. You can call for professional medical advice regarding medical situations. Check with your health plan option for the telephone number

Understanding Your Plan Options

To maximize your health benefits, it is important to fully understand how each SHBP option works. This brief overview will help you determine which option best fits your health care needs. **Keep in mind that failure to use in-network providers could cost you more.**

Consumer Driven Health Plan Options

Health Reimbursement Account (HRA)

The HRA is a consumer driven health care option whose plan design offers you a different approach for managing your health care needs. It is similar to that of the PPO with an in-network and out-of-network benefit, except the SHBP funds \$500 for single coverage and \$1,000 for family coverage to a HRA that can be used to provide first dollar coverage for eligible health care expenses including pharmacy. The amount in your HRA helps offset the deductible (bridge). The Plan also offers unlimited wellness benefits based on age and gender national guidelines when seeing in-network providers only. You will pay co-insurance after you have satisfied the deductible rather than co-payments for medical expenses and prescription drugs.

The BlueCross BlueShield of Georgia Lumenos with Health Reimbursement Account (HRA) offers a network of more than 700,000 participating physicians through the BlueCross BlueShield BlueCard PPO Network. **The BCBSGa Lumenos HRA Plan requires that after using all HRA dollar credits, you satisfy the entire family deductible before any benefits are paid.** This does not apply to wellness. You do not have to pay the provider at the time of service except for pharmacy. *See pages 14–21 for a benefits comparison.*

The UnitedHealthcare (UHC) Definity with Health Reimbursement Account (HRA) offers a network of more than 520,000 participating physicians through the UHC PPO Network. The UHC Definity HRA Plan offers a debit card that can be used when seeing in-network providers or when purchasing prescription drugs from an in-network pharmacy. *See pages 14–21 for a benefits comparison.*

Considerations:

- Unused dollars in your HRA account rollover to the next Plan Year if you are still participating in this option
- HRA dollar credits can be used with the HRA Option only
- If you enroll during the year, your HRA dollar credits will be pro-rated based on the number of months remaining in the Plan Year (which is calendar)
- If you experience a qualifying event and change tiers from single to family coverage, your new HRA dollar credits will be pro-rated based on the number of months remaining in the Plan Year
- If you experience a qualifying event and change tiers from family to single coverage, your HRA dollar credits will not be reduced
- Unused dollars in the HRA account will be forfeited if you change options during the Retiree Option Change Period or qualifying event or terminate employment, even if you re-enroll in a subsequent Plan Year
- There is not a separate deductible and co-insurance for out-of-network



health tip:

Experts agree that exercise is the best predictor of long-term weight control. Rapid weight loss can lower your metabolism because the body thinks it is starving and makes it harder to lose weight.

High Deductible Health Plan (HDHP) with a Health Savings Account (HSA)

The High Deductible Health Plan (HDHP) is a consumer driven health care option whose plan design is very similar to that of the PPO with an in-network and out-of-network benefit. The HDHP offers you the use of the UHC PPO network. This option offers 100 percent unlimited wellness benefits based on national age and gender guidelines. In return for a low monthly premium, you must satisfy a higher deductible that applies to all health care expenses except preventive care. **If you have family coverage, you must meet the 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) for yourself and 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.*

HDHP Considerations:

- You must satisfy a separate in-network and out-of-network deductible
- You must satisfy the family deductible before benefits are payable for any member
- You pay co-insurance after meeting the family deductible for all medical expenses



health tip:

**No more than 30 percent
of your daily calories
should be from fat.**

Health Savings Account (HSA)

An HSA is like a personal savings account with investment options for health care, except it's all tax-free. You may still open an HSA with an independent HSA administrator/custodian and may locate HSA Administrators at www.hsafinder.com/sitemap.shtml.

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) Health Care Spending Account (HCSA) or any other non-qualified medical plan.

- You can make contributions to an HSA only when enrolled in the HDHP as an active member (employee or retiree)
- You can contribute up to \$2800 single, \$5800 family as long as you are enrolled in the HDHP. 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
- 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 care plan (see IRS Publication 502 at www.irs.gov)
- You can contribute additional dollars if you are 55 or older (see IRS Publication 969 at www.irs.gov)

PPO Option

A Preferred Provider Organization (PPO) allows you to receive benefits from participating in-network and out-of-network providers. In order to receive the highest level of benefit coverage and avoid filing claims and balance billing, you should use an in-network provider. If you choose to use an out-of-network provider, the reimbursement will be at a lower

level of benefit coverage. No election of a primary care physician or referral to specialists is required. This option requires you to satisfy a deductible with coinsurance and has an out-of-pocket maximum. When you meet the maximum, the PPO pays your covered services at 100 percent. The PPO option offers you access to a network of more than 13,000 participating physicians and access to every acute care Georgia hospital through the UnitedHealthcare PPO network. You also have the added benefit of access to a national network of participating providers and hospitals across the United States.

Considerations:

- Out-of-network benefits are paid at 60 percent with balance billing
- Co-payments do not apply toward deductibles or out-of-pocket maximum unless otherwise noted
- You must satisfy a separate in-network and out-of-network deductible and separate out-of-pocket maximum

Indemnity Option

If you are currently participating in this option, you may continue to do so in 2008, but this Plan option is not accepting new members. *You will receive a benefits comparison chart in the mail prior to Retiree Option Change Period.*

HMO Options

A Health Maintenance Organization (HMO) allows you to receive benefits from participating providers in the HMO. The SHBP offers BlueCross BlueShield of Georgia Bluechoice HMO, UnitedHealthcare Choice HMO, and Kaiser Permanente HMO. These options are available to SHBP eligible employees who live or work in the county or surrounding counties in which an HMO is offered. You are responsible for selecting a Primary Care Physician (PCP) from a list of participating providers unless you participate in the UnitedHealthcare Choice Option. Your PCP must provide a referral before you see another provider, including specialists, for your expenses to be covered (except in emergencies and other limited cases). If you receive care from a provider other than your PCP, without your PCP's referral, there is no coverage even if the physician or facility is in the HMO network.

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 amount. *See page 14 for more information.*

Considerations:

- Verify provider participation before selecting an HMO Option
- Coverage is available only when using in-network providers (except in cases of emergencies)
- Diagnostic testing and lab services performed at independent radiology and lab offices located in the Kaiser facilities are subject to deductible and co-insurance

Medicare Advantage Plan with Part D (MAPD) Option

The name of the Medicare Option offered by Kaiser Permanente is Senior Advantage.

Kaiser Permanente offers a Medicare Advantage Plan with Part D (MAPD Plan). This option is offered only to retirees who are enrolled in Medicare Part A or B and who live in the Kaiser Permanente service area. If you choose the Senior Advantage Plan, you do not have to enroll in a stand-alone Medicare Prescription Drug Plan. If you currently have an existing Part D Plan and enroll in the Senior Advantage, Medicare will automatically cancel your existing Part D Plan. Senior Advantage is a MAPD Plan, which will fulfill your Part D obligation with SHBP. Your prescription coverage (PDP) will be creditable with flat co-pays. See the benefit design on page 14. See chart below for a listing of counties serviced by the Kaiser Permanente Senior Advantage.

Points to Consider

- You will pay an SHBP premium, but it will be lower than the regular HMO Option premiums. See your Personalized Change Form for premium information.
- You will have the advantage of lower out-of-pocket costs and reduced paperwork. All your services and payments will be coordinated through Kaiser Permanente.
- The benefits available through the Kaiser Permanente Senior Advantage Plan are similar to that of the regular HMO.
- You must use providers in the Kaiser Permanente Senior Advantage network. The affiliated provider network differs from the regular HMO, but all Kaiser Permanente facilities are covered under both plans.
- To enroll in Kaiser Permanente Senior Advantage, you must complete the Kaiser Permanente Senior Advantage CMS enrollment application form. Please call Kaiser Permanente at 404-233-3700 or 800-956-1358 to obtain your enrollment materials, complete and mail back to Kaiser.
- Check the Kaiser Permanente Senior Advantage option on your personalized change form and return to SHBP during the ROCP.

Kaiser Permanente Senior Advantage Coverage by County

The following Georgia counties are covered by Kaiser Permanente Senior Advantage Plan:

- | | | | | |
|------------|-----------|-----------|------------|------------|
| • Barrow | • Clayton | • DeKalb | • Fulton | • Newton |
| • Bartow | • Cobb | • Douglas | • Gwinnett | • Paulding |
| • Butts | • Coweta | • Fayette | • Hall | • Rockdale |
| • Cherokee | • Coweta | • Forsyth | • Henry | • Spalding |
| | | | | • Walton |

Consumer Choice Options (CCO)

This plan option applies to all SHBP options (except Indemnity) and allows you to nominate (request) a Georgia out-of-network provider to be reimbursed as an in-network provider. This in-network relationship between you and the provider exists only for you and the provider. The out-of-network provider must be licensed and located in Georgia and accept the nomination, fees and conditions of the network and be approved by the network BEFORE you receive any services from that provider. You must also follow this process for each dependent wishing to see an out-of-network provider. For further details and to obtain the necessary paperwork, please call the selected plan option member services department.

Considerations:

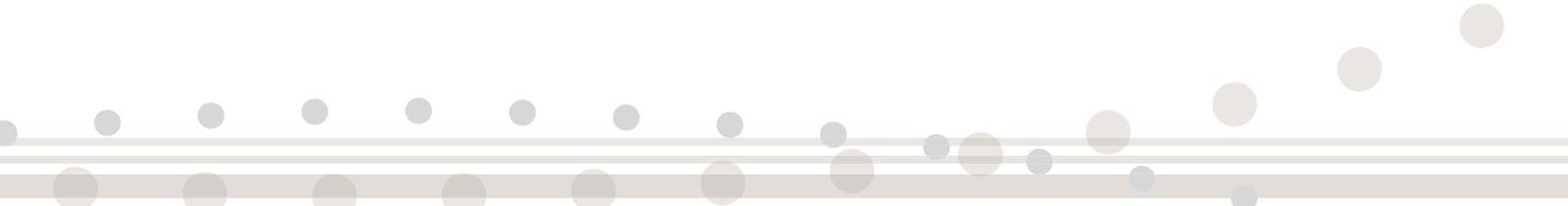
- There is no guarantee that the provider you wish to nominate will accept your nomination or be approved by the network
- Similar to the other options, once you choose CCO, you cannot change options until the following ROCP unless you experience a qualifying event
- The CCO option does not provide enhanced benefits
- Only providers located and licensed in Georgia are eligible for nomination
- Providers may terminate their participation at anytime during the Plan Year

Considerations that Apply to All SHBP Options:

- Annual dollar and visit limitations, deductibles and out-of-pocket spending limits are based on the Plan Year, January 1, 2008 to December 31, 2008
- Lifetime benefit maximums are combined totals among the PPO, HRA, Indemnity, HDHP and HMO Options
- In-network covered services will apply to the in-network deductible and out-of-pocket limit
- A change to the provider network is not a qualifying event and the member may not change Plan options during the Plan Year
- Charges from nonparticipating providers are subject to balance billing. These charges are the member's responsibility and do not count toward deductibles or out-of-pocket spending limits
- Co-payments do not apply toward deductibles or out-of-pocket limits for the Indemnity, PPO and HMO options
- Out-of-network covered services apply to the out-of-network deductible and out-of-pocket limit for the PPO and HDHP. In HMOs, there is no out-of-network coverage, except in limited cases
- Some services may require prior authorization to be covered. Also, some services may have limitations not contained in this summary
- Each Plan offers a Consumer Choice Option (CCO). *See above for details*
- Contact each plan vendor directly for more details regarding covered services, exclusions and limitations. Telephone numbers can be found on the inside cover of this guide

health tip:

To lose weight, burn more calories than you consume each day. Take the stairs instead of the elevator. Instead of watching TV on the weekend, take a walk or ride your bicycle.



SHBP Eligibility

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

Eligible dependents are:

- **Your legally married spouse**, as defined by Georgia Law
- **Your never-married dependent children who are:**
 1. **Natural or legally adopted children under age 19**, unless they are eligible for coverage as employees. Children that are legally adopted through the judicial courts become eligible only after they are placed in your physical custody
 2. **Stepchildren under age 19 who live with you** at least 180 days per year and for whom you can provide documentation satisfactory to the Plan that they are your dependents
 3. **Other children under age 19** if they live with you permanently and legally depend on you for financial support – as long as you have a court order, judgment or other satisfactory proof from a court of competent jurisdiction
 4. **Your natural children, legally adopted children or stepchildren who were covered under the SHBP before age 19 from categories 1 and 2 above** who are physically or mentally disabled prior to reaching age 19 and who depend on you for primary support may continue their existing Plan coverage past age 19
 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 fully accredited 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
- A change to single coverage is allowed at any time
- Discontinue coverage at any time; may not enroll late

Making Changes When You Have a Qualifying Event

The option choice you make during the ROCP will stay in effect through December 31, 2008 unless you experience a qualifying event. You must 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 SPD. You can contact the SHBP Call Center 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

Documentation Confirming Eligibility for Your Spouse or Dependents

- **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
- **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

You have 31 days from the date of the qualifying event or the day of the request for coverage, whichever is later, to provide the qualifying event documentation and/or dependent verification documentation.

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.

health tip:

As much as 25 percent of any weight loss may come from muscle. Weight lifting will build muscle increasing your metabolism. Muscle keeps your metabolism revved up burning calories, fat and sugar.



Benefits Comparison

Schedule of Benefits for You and Your Dependents for January 1, 2008 – December 31, 2008

Covered Services	PPO OPTION		HRA OPTION	
	In-network	Out-of-network	In-network Definity or Lumenos	Out-of-network Definity or Lumenos
Covered Services	<i>The Plan Pays:</i>		<i>The Plan Pays:</i>	
Maximum Lifetime Benefit (combined for all SHBP Options)	\$2 million		\$2 million	
Pre-Existing Conditions (First year in Plan only, subject to HIPAA)	\$1,000		None	
Lifetime Benefit Limit for Treatment of: (combined for PPO Option and HDHP) • Temporomandibular joint dysfunction (TMJ) • Substance abuse	\$1,100 3 episodes		\$1,100 3 episodes	
Deductibles/Co-Payments: • Deductible—individual • Deductible—family maximum	\$500 \$1,500	\$600 \$1,800	\$1,000* \$2,000* <i>*HRA credits will reduce this amount.</i>	
• Hospital deductible per admission	\$250		Not applicable	
Annual Out-of-pocket Limits: • Individual • Family	\$1,100 \$2,200	\$2,200 \$4,400	\$2,000* \$4,000* <i>*HRA credits will reduce this amount.</i>	
HRA Credits: • Individual • Family combined	None		\$500 \$1000 <i>*un-used credits roll to next plan year.</i>	
Physicians' Services				
Primary Care Physician or Specialist Office or Clinic Visits: Treatment of illness or injury	100% after a \$30 per office visit co-payment; not subject to deductible	60% coverage; subject to deductible	90% coverage; subject to deductible	60% coverage; subject to deductible
Primary Care Physician or Specialist Office or Clinic Visits for the Following: • Wellness care/preventive health care • Annual gynecological exams (these services are not subject to the deductible)	100% after \$30 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.
Maternity Care (prenatal, delivery and postpartum)	90% coverage; not subject to deductible after initial \$30 co-payment	60% coverage; subject to deductible	90% coverage; subject to deductible	60% coverage; subject to deductible

Dollar amounts, visit limitations, deductibles and out-of-pocket limits are based on a January 1 – December 31, 2008 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	BlueChoice, Kaiser Permanente, UnitedHealthcare	
<i>The Plan Pays:</i>		<i>The Plan Pays:</i>	<i>HMO Plan Differences:</i>
\$2 million		\$2 million	Kaiser Permanente SA – unlimited
None		None	
\$1,100 3 episodes		No separate lifetime benefit limit	
\$1,100 \$2,200*	\$2,200 \$4,400*	\$200 \$400	
<i>*You must meet the family deductible before benefits are payable for any family member.</i>			
Not applicable		Not applicable	
\$1,700 \$2,900	\$3,800 \$7,000	\$1,000 \$2,000	Kaiser Permanente SA \$1,000 individual, \$2,000 per family per Plan Year
None		None	
90% coverage; subject to deductible	60% coverage; subject to deductible	100% after a per visit co-payment** of \$20 for primary care and \$25 for specialty care	**Includes lab and x-rays done in the physician's office. Kaiser – lab and x-rays may be subject to deductible.
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 \$20 for primary care and \$25 for specialty care. No co-payment for immunizations and mammograms.	No primary care physician designation or specialist referral for UHC.
90% coverage; subject to deductible	60% coverage; subject to deductible	100% after initial \$25 co-payment	

Chart continued pg. 16

	PPO OPTION		HRA OPTION	
	In-network	Out-of-network	In-network Definity or Lumenos	Out-of-network Definity or Lumenos
Physicians' Services	<i>The Plan Pays:</i>		<i>The Plan Pays:</i>	
Physician Services Furnished in a Hospital • Visits; surgery in general, including charges by surgeon, anesthesiologist, pathologist and radiologist	90% coverage; subject to deductible	60% coverage; subject to deductible	90% coverage; subject to deductible	60% coverage; subject to deductible
Physician Services for Emergency Care Non-emergency use of the emergency room not covered	90% coverage; subject to deductible	90% coverage; subject to in-network deductible	90% coverage; subject to deductible	90% coverage; subject to deductible
Outpatient Surgery— • When billed as office visit	90% coverage; subject to deductible	60% coverage; subject to deductible	90% coverage; subject to deductible	60% coverage; subject to deductible
• When billed as outpatient surgery at a facility	90% coverage; subject to deductible	60% coverage; subject to deductible	90% coverage; subject to deductible	60% coverage; subject to deductible
Allergy Shots and Serum	100% for shots and serum; \$30 per visit co-payment not subject to deductible (no co-payment if office visit not billed)	60% coverage; subject to deductible	90% coverage; subject to deductible	60% coverage; subject to deductible
Hospital Services				
Inpatient Services • Inpatient care, delivery and inpatient short-term acute rehabilitation services	90% coverage after deductible; and subject to a \$250 per admission deductible	60% coverage after deductible; and subject to a \$250 per admission deductible	90% coverage; subject to deductible	60% coverage; subject to deductible
• Well-newborn care	100% coverage; not subject to deductible	60% coverage; not subject to deductible	90% coverage; not subject to deductible	60% coverage; not subject to deductible
Outpatient Surgery— Hospital/facility	90% coverage; subject to deductible	60% coverage; subject to deductible	90% 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	90% coverage after a \$100 per visit co-payment; co-payment waived if admitted; subject to in-network deductible	90% coverage after a \$100 per visit co-payment; co-payment waived if admitted; subject to in-network deductible	90% coverage; subject to deductible	
Outpatient Testing, Lab, etc.				
Laboratory; X-Rays; Diagnostic Tests; Injections— including medications covered under medical benefits—for the treatment of an illness or injury	90% coverage; subject to deductible	60% coverage; subject to deductible	90% coverage; subject to deductible	60% coverage; subject to deductible

HIGH DEDUCTIBLE OPTION		HMO OPTIONS	
In-network	Out-of-network	BlueChoice, Kaiser Permanente, UnitedHealthcare	
<i>The Plan Pays:</i>		<i>The Plan Pays:</i>	<i>HMO Plan Differences:</i>
90% coverage; subject to deductible	60% coverage; subject to deductible	90% coverage; subject to deductible	
90% coverage; subject to deductible	90% coverage; subject to deductible	100% (\$100 co-pay applies to facility expenses)	Non-emergency use of the emergency room not covered. Applies to all plan options.
90% coverage; subject to deductible	60% coverage; subject to deductible	100% after \$20 co-payment for PCP, \$25 for specialist, if billed as office visit	Kaiser Permanente – 90% coverage; subject to deductible
90% coverage; subject to deductible	60% coverage; subject to deductible	90% coverage; subject to deductible	
90% coverage; subject to deductible	60% coverage; subject to deductible	100% for shots and serum after a \$25 per visit co-payment	Kaiser Permanente – \$5 for shots and \$50 for a three-month supply of serum. UnitedHealthcare – no co-pay if office visit not billed.
90% coverage; subject to deductible	60% coverage; subject to deductible	90% 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	90% coverage; subject to deductible	90% coverage; subject to deductible	
90% coverage; subject to deductible	90% coverage; subject to deductible	100% after a \$100 per visit co-payment; co-payment waived if admitted; subject to deductible	Non-emergency use of the emergency room not covered. Applies to all plan options.
90% coverage; subject to deductible	60% coverage; subject to deductible	90% coverage; subject to deductible	Kaiser Permanente – lab and x-rays may be subject to deductible. UnitedHealthcare – independent lab/x-ray are payable at 100%.

Chart continued pg. 18

	PPO OPTION		HRA OPTION	
	In-network	Out-of-network	In-network Definity or Lumenos	Out-of-network Definity or Lumenos
Behavioral Health	<i>The Plan Pays:</i>		<i>The Plan Pays:</i>	
Mental Health and Substance Abuse Inpatient Facility NOTE: All services require prior authorization. Combined days include in-network and out-of-network visits.	90% coverage; subject to deductible; limited to 45 days combined per Plan Year	60% coverage; subject to deductible; limited to 45 days combined per Plan Year	90% coverage; subject to deductible limited to 30 days combined per Plan Year	60% coverage; subject to deductible limited to 30 days combined per Plan Year
Partial Day Hospitalization and Intensive Outpatient NOTE: Notification required. (Mental Health and Substance Abuse) Combined days include in-network and out-of-network visits.	90% coverage; subject to deductible; limited to 60 days combined per Plan Year (includes partial day and intensive outpatient)	No benefit	90% coverage; subject to deductible; limited to 30 days combined per Plan Year	60% coverage; subject to deductible; limited to 30 days combined per Plan Year
Professional Charges Inpatient (Mental Health and Substance Abuse) Combined visits include in-network and out-of-network visits.	90% coverage; subject to deductible; limited to 1 visit per authorized day combined per Plan Year	60% coverage; subject to deductible; limited to 1 visit per authorized day combined per Plan Year	90% coverage; subject to deductible; limited to 30 visits per authorized day combined per Plan Year	60% coverage; subject to deductible; limited to 30 visits per authorized day combined per Plan Year
Mental Health and Substance Abuse Outpatient Visits NOTE: Notification required.	90% coverage; subject to deductible; limited to 50 visits per Plan Year (the 50 visit limit includes any out-of-network visits)	60% coverage; subject to deductible; limited to 25 visits per Plan Year (not to exceed a total of 50 visits combined)	90% coverage; subject to deductible; limited to 30 visits per Plan Year (includes any out-of-network visits)	60% coverage; subject to deductible; limited to 30 visits per Plan Year (includes any in-network visits)
Dental				
Dental and Oral Care NOTE: Coverage for most procedures for the prompt repair of sound natural teeth or tissue for the correction of damage caused by traumatic injury.	90% coverage; subject to deductible	60% coverage; subject to deductible	90% 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.	90% coverage; subject to deductible	60% coverage; subject to deductible	90% coverage; subject to deductible	60% coverage; subject to deductible
Vision				
Routine Eye Exam	90% coverage; not subject to deductible; limited to one eye exam every 24 months	Eye exam not covered	Contact HRA vendor directly for more information	
Other Coverage				
Ambulance Services for Emergency Care NOTE: "Land or air ambulance" to nearest facility to treat the condition.	90% coverage; subject to deductible	90% coverage; subject to deductible	90% coverage; subject to deductible	90% coverage; subject to deductible

HIGH DEDUCTIBLE OPTION		HMO OPTIONS	
In-network	Out-of-network	BlueChoice, Kaiser Permanente, UnitedHealthcare	
<i>The Plan Pays:</i>		<i>The Plan Pays:</i>	<i>HMO Plan Differences:</i>
90% coverage; subject to deductible limited to 30 days combined per Plan Year	60% coverage; subject to deductible limited to 30 days combined per Plan Year	90% coverage; not subject to deductible and limited to 30 days combined per Plan Year	Kaiser Permanente – 90% of coverage; subject to deductible and unlimited days for mental health and detoxification; 30-day limit for substance abuse ----- Kaiser Permanente SA – 90% of coverage; subject to deductible and unlimited days for mental health, substance abuse and detoxification.
90% coverage; subject to deductible limited to 60 days combined per Plan Year	60% coverage; subject to deductible limited to 30 days combined per Plan Year	Each HMO may or may not offer this benefit; contact the HMO for more information	
90% coverage; subject to deductible limited to 1 visit per authorized day combined per Plan Year	60% coverage; subject to deductible limited to 1 visit per authorized day combined per Plan Year	90% coverage; not subject to deductible	Kaiser Permanente – 90% coverage; subject to deductible
90% coverage; subject to deductible limited to 50 visits combined per Plan Year (includes any out-of-network visits)	60% coverage; subject to deductible limited to 25 visits combined per Plan Year (includes any out-of-network visits)	100% after \$25 per visit co-payment; limited to 25 visits per Plan Year	Kaiser Permanente – \$25 co-payment, 100% coverage, unlimited visits, Mental Health and Detoxification; limited to 25 visits for substance abuse ----- Kaiser Permanente SA – 100% after \$25 co-payment. Unlimited visits for mental health, substance abuse and detoxification.
90% coverage; subject to deductible	60% coverage; subject to deductible	100% after applicable co-payment, if inpatient/outpatient facility; subject to deductible	Contact the respective vendor
90% coverage; subject to deductible	60% coverage; subject to deductible	100% after applicable co-payment for related surgery and diagnostic services; excludes appliances and orthodontic treatment; if inpatient/outpatient facility, 90% subject to deductible	Kaiser Permanente – 50% for non-surgical treatment; excludes appliances and orthodontic treatment; if inpatient/outpatient facility; 90% subject to deductible
90% coverage; not subject to deductible; limited to one eye exam every 24 months	Eye exam not covered	Contact HMO directly for more information	UHC includes \$200 benefit for glasses and contacts
90% coverage; subject to deductible	90% coverage; subject to deductible	100%	Kaiser Permanente – 100% after a \$50 per trip co-payment when medically necessary.

Chart continued pg. 20

	PPO OPTION		HRA OPTION	
	In-network	Out-of-network	In-network Definity or Lumenos	Out-of-network Definity or Lumenos
Other Coverage	<i>The Plan Pays:</i>		<i>The Plan Pays:</i>	
Urgent Care Services	90% coverage after a \$45 per visit co-payment; subject to deductible	60% coverage; subject to deductible	90% coverage; subject to deductible	60% coverage; subject to deductible
Home Health Care Services NOTE: Prior approval required	90% coverage; subject to deductible	60% coverage; subject to deductible	90% coverage; subject to deductible	60% coverage; subject to deductible
Skilled Nursing Facility Services NOTE: Prior approval required	90% coverage after deductible; up to 120 days per Plan Year; subject to a \$250 per admission deductible	Not covered	90% 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	90% coverage; subject to deductible	60% coverage; subject to deductible
Durable Medical Equipment (DME)—Rental or purchase	90% coverage; subject to deductible ----- (UHC options require notification over \$1000)	60% coverage; subject to deductible	90% coverage; subject to deductible	60% coverage; subject to deductible
Outpatient Acute Short-Term Rehabilitation Services <ul style="list-style-type: none"> • Physical Therapy • Speech Therapy • Occupational Therapy • Other short term rehabilitative services 	90% coverage; 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)	90% 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.	90% coverage; after a \$30 per visit co-payment; not subject to deductible	60% coverage; subject to deductible	90% coverage; subject to deductible	60% coverage; subject to deductible
Transplant Services NOTE: Prior approval required. Lumenos lifetime benefit maximum \$500,000 (except for kidney or cornea).	90% coverage at contracted transplant facility; subject to deductible and \$250 per admission deductible	Not covered	90% coverage; subject to deductible	60% coverage; subject to deductible
Pharmacy				
Tier 1 Co-payment NOTE: No Tiers in HRA Option	\$10	\$10*	90% coverage; subject to deductible	60% coverage; subject to deductible
Tier 2 Co-payment	\$30	\$30*		
Tier 3 Co-payment	\$100	\$100*		

*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		HMO OPTIONS	
In-network	Out-of-network	BlueChoice, Kaiser Permanente, UnitedHealthcare	
<i>The Plan Pays:</i>		<i>The Plan Pays:</i>	<i>HMO Plan Differences</i>
90% coverage; subject to deductible	60% coverage; subject to deductible	100% after \$25 co-payment	BlueChoice – referral required. Kaiser Permanente – 100% after \$30 co-payment
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	90% coverage; up to 120 days per Plan Year; subject to deductible	Kaiser Permanente – up to 60 days per Plan Year; subject to deductible Kaiser Permanente SA – up to 100 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	UnitedHealthcare – notification required for items over \$1,000
90% coverage up to 40 visits 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 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 Plan Year	Kaiser Permanente SA – unlimited visits
90% coverage; subject to deductible	60% coverage; subject to deductible	100% coverage after \$25 co-payment per visit	
90% coverage at contracted transplant facility; subject to deductible	Not covered	90% coverage; subject to deductible	
80% coverage; subject to deductible \$10 min./\$100 max.	60% coverage; subject to deductible \$10 min./\$100 max.	\$10	Kaiser Permanente – Kaiser facility: \$10 Network Pharmacies: \$16
80% coverage; subject to deductible \$10 min./\$100 max.	60% coverage; subject to deductible \$10 min./\$100 max.	\$25	Kaiser Permanente – Kaiser facility: \$25 Network Pharmacies: \$31
80% coverage; subject to deductible \$10 min./\$100 max.	60% coverage; subject to deductible \$10 min./\$100 max.	\$50	Kaiser Permanente – N/A

HRA and HSA Considerations

	HRA	HSA
Overview	A tax-exempt account that reimburses employees or retirees and dependents for qualified medical expenses. Funded by SHBP only.	A tax-exempt custodial account that exclusively pays for qualified medical expenses of the employee or retiree and his or her dependents. Can be funded by employee, retiree, employer, or other party.
Who is eligible?	Available to SHBP members enrolled in the BCBS Lumenos or UHC DeFINITY Options	Available to SHBP members who elect HDHP.
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 Part A or Part B.
Who owns the money in these accounts?	SHBP. Money reverts back to SHBP upon loss of SHBP HRA coverage.	The employee or 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 or change of coverage.	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.

State Health Benefit Plan Medicare Policy

- Georgia law requires that SHBP pay benefits after Medicare has paid.
- SHBP will calculate premiums and claim payments based upon Medicare enrollment for retirees over 65 or those eligible for Medicare due to disability.
- Premiums will be based on the Parts of Medicare (A, B, or D) that you have. There will be no adjustments in premiums because you have other coverage such as TRICARE, VA or other group coverage since SHBP may have potential primary liability.
- SHBP will coordinate benefits for members who are enrolled in Medicare A, B or D.
- SHBP will pay primary benefits on members not eligible or not enrolled in Medicare, but you will pay a higher premium.
- If you enroll in Medicare (A, B, or D), please send a copy of your Medicare cards by the first of the month in which you are eligible for Medicare. Premiums cannot be reduced until copies of your Medicare cards are received and the change in premium is processed by the retirement system. Delay in submission of Medicare information does not qualify for a refund of the difference in premiums.

Medicare information is available at:

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

Medicare Part D Information

If you are not enrolled in Medicare Part D, you may enroll during the Medicare annual open enrollment period; November 15 – December 31, 2007. This open enrollment is held by the Centers for Medicare and Medicaid (CMS) and not by SHBP. In many cases, you do not need the Medicare Part D enhanced prescription drug plan (PDP). Your individual pharmacy needs will indicate the level of coverage that is best for you.

Coordination of Pharmacy Benefits between your PDP and SHBP

- Each time you go to the pharmacy, present both your Medicare Part D and SHBP identification cards.
- When you reach the PDP coverage gap, you should still present both identification cards and you will pay your SHBP co-payment.
- If your pharmacy can't bill both your Medicare Part D and SHBP, you will have to file a paper claim with the SHBP vendor or change drug stores.
- Check with the vendor regarding limits to submit a paper claim.



GEORGIA DEPARTMENT OF
COMMUNITY HEALTH

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

October 1, 2007

Important Notice from the SHBP for Medicare Eligible Members

About Your Prescription Drug Coverage with BlueChoice HMO, BlueCross BlueShield Lumenos HRA, Kaiser Permanente, Indemnity, PPO, UnitedHealthcare Choice HMO, UnitedHealthcare Definity HRA and Medicare

For Plan Year: January 1–December 31, 2008

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 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.

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 BlueChoice HMO, BlueCross BlueShield Lumenos HRA, Kaiser Permanente, Indemnity, PPO, UnitedHealthcare Choice HMO and UnitedHealthcare Definity HRA Options under SHBP are, 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, on average, at least as good as standard Medicare prescription drug coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to 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. This may mean that you may have to wait to join a Medicare drug plan and that you may pay a higher premium (a penalty) if you join later. You may pay that higher premium (a penalty) as long as you have Medicare prescription drug coverage. However, if you lose creditable prescription drug coverage, through no fault of your own, you will be eligible for a sixty (60) day Special Enrollment Period (SEP) because you lost creditable coverage to join a Part D plan. In addition if you lose your SHBP coverage, you will be eligible to join a Part D plan at that time using an Employer Group Special Enrollment Period. You should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area.

If you decide to join a Medicare drug plan, your SHBP coverage will be affected. See below for more information about what happens to your current coverage if you join a Medicare drug plan.

If you elect Part D and keep your SHBP coverage under BlueChoice HMO, BlueCross BlueShield Lumenos HRA, Kaiser Permanente, Indemnity, PPO, UnitedHealthcare Choice HMO and UnitedHealthcare Definity HRA Options, these plans will coordinate with Part D coverage.

If you do decide to join a Medicare drug plan and drop your BlueChoice HMO, BlueCross BlueShield Lumenos HRA, Kaiser Permanente, Indemnity, PPO, UnitedHealthcare Choice HMO or UnitedHealthcare Definity HRA coverage, be aware that you and your dependents will not be able to get your SHBP coverage back. 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 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 base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without coverage, your premium may consistently be at least 19% higher than the 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 Current Prescription Drug Coverage...

Contact the SHBP Call Center at (404) 656-6322 or (800) 610-1863 for further information. 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 your SHBP coverage changes. You also may request a copy.

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 whether or not you are required to pay a higher premium (a penalty).

Date: October 1, 2007

Name of Entity/Sender: State Health Benefit Plan

Office: Call Center

Address: P. O. Box 38342, Atlanta, GA 30334

Phone Number: (404) 656-6322 or (800) 610-1863

October 1, 2007



GEORGIA DEPARTMENT OF
COMMUNITY HEALTH

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

Important Notice from the SHBP for Medicare Eligible Members

About Your Prescription Drug Coverage with the High Deductible Health Plan and Medicare

For Plan Year: January 1–December 31, 2008

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 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.

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 under the High Deductible Health Plan (HDHP) Option, is, on average for all plan participants, NOT expected to pay out as much as standard Medicare prescription drug coverage pays and 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 through the HDHP offered by the SHBP**
3. 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. Read this notice carefully as it explains your options

Consider joining a Medicare drug plan. You can keep your HDHP coverage offered by the SHBP. You can keep the coverage regardless of whether it is as good as Medicare drug plan. However, because your existing coverage is, on average, NOT at least as good as standard Medicare prescription drug coverage, you may pay a higher premium (a penalty) if you later decide to 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. This may mean that you may have to wait to join a Medicare drug plan and that you may pay a higher premium (a penalty) if you join later. You may pay that higher premium (a penalty) as long as you have Medicare prescription drug coverage. However, if you lose your HDHP coverage under the SHBP; you will be eligible to join a Part D plan at that time using an Employer Group Special Enrollment Period.

You Need to Make a Decision

When you make your decision, you should compare your current coverage, including which drugs are covered, with the coverage and cost of the plans offering Medicare prescription drug coverage in your area. If you decide to join a Medicare drug plan, your HDHP coverage under SHBP will be affected. See below for more information about what happens to your current coverage if you join a Medicare drug plan.

- If you enroll in Medicare Part D when you become eligible for Medicare Part D, you can keep your HDHP coverage even if you elect Part D and the HDHP will coordinate benefits with 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.
- 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.
- If you go 63 continuous days or longer without 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 base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without coverage, your premium may consistently be at least 19% higher than the 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.

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 your SHBP coverage changes. You also may request a copy.

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).

Date: October 1, 2007

Name of Entity/Sender: State Health Benefit Plan

Office: Call Center

Address: P. O. Box 38342, Atlanta, GA 30334

Phone Number: (404) 656-6322 or (800) 610-1863

Department of Community Health

Privacy Notice

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

The Plan's Privacy Commitment to You

The Georgia Department of Community Health (DCH) understands that information about you and your family is personal. DCH is committed to protecting your information. This notice tells you how DCH uses and discloses information about you. It tells you your rights and the Plan's requirements about your information.

Understanding the Type of Information that the Plan Has

SHBP records indicate that you have previously provided information to us. This information included your name, address, birth date, phone number, Social Security Number, gender and Medicare information if applicable. It may also have included health information. When your health care providers send claims to the Plan's claims administrator for payment the claims include your diagnoses and the medical treatments you received. For some medical treatments, your health care providers send additional medical information to the Plan such as doctor's statements, x-rays or lab test results.

Your Health Information Rights

You have the following rights regarding the health information that DCH has about you:

- You have the right to see and obtain a copy of your health information. An exception is psychotherapy notes. Another exception is information that is needed for a legal action relating to DCH
- You have the right to ask DCH to change health information that is incorrect or incomplete. DCH may deny your request under certain circumstances
- You have the right to request a list of the disclosures that DCH has made of your health information beginning in April 2003
- You have the right to request a restriction on certain uses or disclosures of your health information. DCH is not required to agree with your request
- You have the right to request that DCH communicates with you about your health in a way or at a location that will help you keep your information confidential
- You have the right to receive a paper copy of this notice. You may ask DCH staff to give you another copy of this notice, or you may obtain a copy from DCH's Web site, www.dch.georgia.gov. Click on HIPAA Privacy Notices

Privacy Law's Requirements

DCH is required by law to:

- Maintain the privacy of your information
- Give you this notice of DCH's legal duties and privacy practices regarding the information that DCH has about you
- Follow the terms of this notice
- Not use or disclose any information about you without your written permission, except for the reasons given in this notice. You may take away your permission at any time, in writing, except for the information that DCH disclosed before you stopped your permission. If you cannot give your permission due to an emergency, DCH may release the information if it is in your best interest. DCH must notify you as soon as possible after releasing the information

In the future, DCH may change its privacy practices. If its privacy practices change significantly, DCH will provide a new notice to you. DCH will post the new notice on its Web site at www.dch.georgia.gov. Click on HIPPA Privacy Notices. This notice was effective April 14, 2003.

How DCH Uses and Discloses Health Care Information

There are some services the Plan provides through contracts with private companies. For example, a health insurance company pays most medical claims to your health care providers. When services are contracted, the Plan may disclose some or all of your information to the company so that they can perform the job the Plan has asked them to do. To protect your information, the Plan requires the company to safeguard your information in accordance with the law.

The following categories describe different ways that the Plan uses and discloses your health information. For each category, we will explain what we mean and give an example.

For Payment

The Plan may use and disclose information about you so that it can authorize payment for the health services that you received. For example, when you receive a service covered by the Plan, your health care provider sends a claim for payment to the claims administrator. The claim includes information that identifies you, as well as your diagnoses and treatments.

For Medical Treatment

The Plan may use or disclose information about you to ensure that you receive necessary medical treatment and services. For example, if you participate in a Disease State Management Program, the Plan may send you information about your condition.

To Operate Various Plan Programs

The Plan may use or disclose information about you to run various Plan programs and ensure that you receive quality care. For example, the Plan may contract with a company that reviews hospital records to check on the quality of care that you received and the outcome of your care.

To Other Government Agencies Providing Benefits or Services

The Plan may give information about you to other government agencies that are giving you benefits or services. The information must be necessary for you to receive those benefits or services and will be authorized by you or by law.

To Keep You Informed

The Plan may mail you information about your health and well-being. Examples are information about managing a disease that you have, information about your managed care choices, and information about prescription drugs you are taking.

For Overseeing Health Care Providers

The Plan may disclose information about you to the government agencies that license and inspect medical facilities, such as hospitals, as required by law.

For Research

The Plan may disclose information about you for a research project that has been approved by a review board. The review board must review the research project and its rules to ensure the privacy of your information. The research must be for the purpose of helping the Plan.

As Required by Law

The Plan will disclose information about you as required by law.

Under the HIPAA Privacy Law, you may authorize the Plan to release your Personal Health Information (PHI) to another individual. If you have authorized the release of PHI to another individual, the personal representative form authorizing the release of your PHI is not transferred between options. This is for the protection of your privacy. If you wish to continue to designate another individual after changing health options, you may be asked to complete a new personal representative form.

For More Information or to Report a Problem

If you have questions and would like additional information, you may contact the SHBP at 404-656-6322 (Atlanta calling area) or 800-610-1863 (outside of Atlanta calling area).

If you believe your privacy rights have been violated:

- You can file a complaint with the Plan by calling the SHBP at 404-656-6322 (Atlanta calling area) or 800-610-1863 (outside of Atlanta calling area), or by writing to: SHBP-HPU, P.O. Box 38342, Atlanta, GA 30334.
- You can file a complaint with the Health and Human Services Office for Civil Rights by writing to: U.S. Department of Health and Human Services Office for Civil Rights, Region IV, Atlanta Federal Center, 61 Forsyth Street SW, Suite 3B70, Atlanta, GA 30323.

There will be no retaliation for filing a complaint.

Health Insurance Portability And Accountability Act (HIPAA) Annual Notice

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

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

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

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

To reduce the pre-existing condition limitation period for your dependents (including your spouse), you must provide the SHBP with a certificate of creditable coverage stating when coverage started and ended for each dependent that you want to cover. Any period of prior coverage for that dependent will reduce the 12-month limitation period if no more than 63 days have elapsed between the dependent's loss of prior coverage and the first day of coverage under the SHBP.

If your dependent (including a spouse) had any break in coverage lasting more than 63 days, your dependent will receive creditable coverage only for the period of time after the break ended.

Within two years after your dependent's former coverage terminated, he or she has the right to obtain a certificate of creditable coverage from his or her former employer(s) to offset the pre-existing condition limitation period under the SHBP. The SHBP will evaluate the certificate of creditable coverage or other documentation to determine whether any of the pre-existing condition limitation period will be reduced or eliminated. After completing the evaluation, the SHBP will notify you as to how the pre-existing condition limitation period will be reduced or eliminated.

Please submit the certificate of creditable coverage to the Plan with your dependent's enrollment paperwork.

Women's Health and Cancer Rights Act

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

Following cancer surgery, the SHBP covers:

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

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

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

Statements of Rights Under the Newborns' and Mothers' Health Protection Act

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

Penalties for Misrepresentation

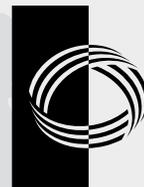
If a SHBP participant misrepresents eligibility information when applying for coverage, during change of coverage or when filing for benefits, the SHBP may take adverse action against the participant, including but not limited to terminating coverage (for the participant and his or her dependent[s])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

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

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



Helping Georgians Stay Healthy



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COMMUNITY HEALTH