

Retiree Decision Guide 2009

**GEORGIA'S
NUTS ABOUT
HEALTH!**

Steps to Maintain Good Health:

- Select the Best Health Care Option
- Seek Preventative Care
- Complete Your Health Assessment
- Participate in Health Coaching
- Take Charge of Your Health



**RETIREE OPTION CHANGE PERIOD
October 10–November 10, 2008**



GEORGIA DEPARTMENT OF
COMMUNITY HEALTH

Phone Numbers/Contact Information

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

Vendor	Member Services	Pharmacy	Web Site
UnitedHealthcare			
Retiree Help Line	877-246-4190		
Definity HRA	800-396-6515		www.myuhc.com/groups/gdch
PPO	877-246-4189 TDD 800-955-8770	800-372-5802	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	800-372-5802	www.myuhc.com/groups/gdch
CIGNA Healthcare			
Retiree Help Line	800-942-6724		
HRA, PPO, HMO, HDHP	800-633-8519 TDD 800-576-1314	800-633-8519	www.cigna.com/shbp
Kaiser Permanente	800-611-1811 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
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

Page 2 of this guide contains Plan changes effective January 1, 2009. Prior to the start of the 2009 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, 2009. 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. Medows, MD, Commissioner *Sonny Perdue, Governor*

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

October 1, 2008

Dear State Health Benefit Plan (SHBP) Member:

Welcome to the 2009 Retiree Option Change Period (ROCP). This year the ROCP dates will be October 10 – November 10, 2008. Retirees will again make their health election on the Web at www.oe2009.ga.gov.

SHBP is committed to providing a comprehensive benefit program with multiple choices while keeping prices affordable for all members. We have also heard your feedback and ideas for improving your benefit program and we are happy to announce some exciting changes that will be offered January 1, 2009:

- To streamline administrative costs and improve network access, SHBP conducted a competitive procurement earlier this year and awarded statewide contracts to **CIGNA Healthcare** and **UnitedHealthcare** (effective January 1, 2009). These two vendors offer the broadest access to providers across the state and proven quality care. Each vendor will offer a Health Reimbursement Arrangement (HRA), High Deductible Health Plan (HDHP), Preferred Provider Organization (PPO), Health Maintenance Organization (HMO) and Medicare Advantage Private Fee-for-Service with Prescription Drugs (MA PFFS-PD) options
- SHBP is excited to offer retirees and/or their eligible dependent(s) who are enrolled in Medicare Parts A and B the opportunity to enroll in one of two Medicare MA PFFS-PD options
- The MA PFFS-PD options are Medicare approved plans that have been structured to offer enhanced benefits while reducing/limiting retirees' out-of-pocket expenses
- For the HRA option, members will see new incentives for wellness/preventative care by completing health assessments and obtaining an annual physical
- Mental health benefits have also been expanded to more closely match those of the medical benefits with unlimited days for inpatient and outpatient treatment

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

Sincerely,

Rhonda M. Medows, M.D.
Commissioner

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Welcome to the Retiree Option Change Period (ROCP) for the State Health Benefit Plan for Coverage Effective January 1, 2009 – December 31, 2009

The ROCP dates are October 10 through November 10, 2008. 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 health 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.oe2009.ga.gov.

Retirees who wish to make a change will make their health election at www.oe2009.ga.gov and the Web site will be open beginning 12:01 a.m. on October 10 and will close at 4:30 p.m. on November 10, 2008.

What's Changing for 2009?

New Offerings

Through a comprehensive and competitive procurement process, CIGNA Healthcare and UnitedHealthcare were chosen to provide your medical and pharmacy benefit plans effective January 1, 2009. Strong statewide and national access to physicians and hospitals as well as documented clinical excellence were the two most critical factors in the award. CIGNA Healthcare and UnitedHealthcare also both demonstrate expertise and innovation in wellness and consumerism, two important areas of focus for SHBP.

New Plan Option Offerings

CIGNA Healthcare and UnitedHealthcare will each offer the following options:

- Health Reimbursement Arrangement (HRA)
- High Deductible Health Plan (HDHP)
- Preferred Provider Organization (PPO)
- Health Maintenance Organization (HMO)
- Medicare Advantage Private Fee for Service Plan with Prescription Drugs (MA PFFS-PD) Plan (retirees age 65 and older)

No Longer Offered

- The Indemnity Option
- The BlueCross BlueShield of Ga BlueChoice HMO and Lumenos plan options
- The Consumer Choice Option (CCO)
- The Kaiser Permanente Option will be frozen and will be offered **only** to individuals currently enrolled in this option

Premiums

- Overall cost increase on average to employees and retirees: 7.5 percent
- The HRA and HDHP options will receive a lower rate increase (0 to 3 percent); non-Consumer Driven Health Plans will receive a larger increase (2 to 10 percent)

Eligibility Changes

Surviving Spouse Coverage

- If a surviving spouse becomes eligible for coverage as an active employee, he/she must be covered under SHBP as an active employee through his/her employer and NOT as a surviving spouse
- When surviving spouse leaves active employment, **he/she must notify SHBP within 31 days** to regain coverage as a surviving spouse

SHBP Acronyms

CDHP – Consumer Driven Health Plan

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

PPO – Preferred Provider Organization

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

SHBP – State Health Benefit Plan

SPD – Summary Plan Description

UHC – UnitedHealthcare

Enhancements and Changes

Enhanced Mental Health and Substance Abuse Benefits

Day limitations no longer apply to the following:

- Inpatient Facility
- Inpatient Professional Charges
- Outpatient Visits
- Partial Day Hospitalization/Intensive Outpatient

NOTE: Number of days and/or visits authorized remain subject to health plan approval

Medicare Advantage Private Fee-for-Service with Prescription Drugs (MA PFFS-PD)

A Medicare Advantage Private Fee-for-Service with Prescription Drugs (MA PFFS-PD) is an approved plan by the Centers for Medicare and Medicaid Services (CMS) – or often called a Medicare Part C Plan. This plan is for retirees and their eligible dependent(s) who are enrolled in Medicare Parts A and B. This option takes the place of your original Medicare (Part A – Hospital and Part B – Medical Insurance benefits.)

These options have enriched benefits and are structured to reduce/limit retirees' out-of-pocket expenses and include Part D prescription drug coverage. If you are currently enrolled in a Medicare Part D plan, CMS will automatically disenroll you from your Part D coverage once your enrollment in a MA PFFS-PD is approved.

- 100% coverage for covered medical expenses once your low, fixed out-of-pocket maximum of \$1,000 has been met for the Plan year. This is important if you are faced with an expensive medical procedure
- No more coordination of benefits with Medicare as this is an all-inclusive plan in place of 'traditional' Medicare
- SHBP has expanded the drugs offered to include coverage on some drugs that are normally not covered by the MA PFFS-PD. This gives you covered drugs **beyond the Medicare Part D drug coverage**
- To receive covered services, you'll simply need to verify your provider will accept the terms of payment and show your CIGNA or UnitedHealthcare ID card at **every** visit

HRA and HDHP Enhancements

- Retiree and Spouse can each earn an additional \$125 in their HRA account by taking an annual physical and completing a health assessment (HRA only)
- No cost for certain asthma, diabetes and cardiac prescriptions for members enrolled and compliant with the disease state management program (HRA only)

- Treatment of Morbid Obesity at approved Centers of Excellence for members who meet the medical guidelines and complete specified requirements (available on HDHP also)
- Allowance for hearing aids up to \$1500 every 5 years (available on HDHP also)
- HRA credits and deductibles will be adjusted as follows:

HRA Deductible and Out-of-Pocket Limit – January 1, 2009						
Tier	2008 HRA Credits	2009 HRA Credits	2008 Deductibles	2009 Deductibles	2008 Maximum In & Out-of-Network Out-of-Pocket Limit	2009 Maximum In & Out-of-Network Out-of-Pocket Limit*
Single	\$500	\$500	\$1,000	\$1,000	\$2,000	\$2,000
Family	\$1,000	\$1,500	\$2,000	\$2,500	\$4,000	\$4,500

*These deductibles will be reduced by the HRA dollar credits.

HDHP Deductibles – January 1, 2009				
Tier	2008 Deductibles	2009 Deductibles	2008 Out-of-Network Deductibles	2009 Out-of-Network Deductibles
Single	\$1,100	\$1,150	\$2,200	\$2,300
Family	\$2,200	\$2,300	\$4,400	\$4,600

PPO Changes

SHBP PPO Out-of-Pocket Limit – January 1, 2009				
Tier	2008 Out-of-Pocket Maximum	2009 Out-of-Pocket Maximum	2008 Out-of-Network Out-of-Pocket Maximum	2009 Out-of-Network Out-of-Pocket Maximum
Single	\$1,100 + co-pays	\$1,500 + co-pays	\$2,200 + co-pays	\$3,000 + co-pays
Family	\$2,200 + co-pays	\$3,000 + co-pays	\$4,400 + co-pays	\$6,000 + co-pays

HMO Changes

- The deductible and maximum out-of-pocket limits are changing
- HMO Office co-pays are increasing to \$30 for primary care and specialists
- HMO co-pays are increasing for preferred prescription drugs from \$25 to \$30 and non-preferred prescription drugs from \$50 to \$75

HMO Deductibles and Out-of-Pocket Limits – January 1, 2009				
Tier	2008 Deductibles	2009 Deductibles	2008 Out-of-Pocket Maximum	2009 Out-of-Pocket Maximum
Single	\$200	\$400	\$1,000 + co-pays	\$1,500 + co-pays
Family	\$400	\$800	\$2,000 + co-pays	\$3,000 + co-pays

Transition of Care

Transition of Care for BlueChoice HMO and Lumenos members and UnitedHealthcare Indemnity and CCO members

- Transition of care may be provided for if treatment is needed after the end of December. To request transition of care, call the Customer Service number shown on your new ID card by December 31, 2008
- If you have any medical or pharmacy claims for services on or before December 31, 2008, these claims must be received by BlueChoice, Lumenos or UnitedHealthcare no later than March 31, 2009. This requirement also applies to any requests for appeals and adjustments. All claims and requests for appeals and adjustments received after March 31, 2009 will be denied. Please contact your 2008 healthcare vendor to obtain the address

SHBP Plan Options

CIGNA Healthcare and UnitedHealthcare Each Offer:

- Health Reimbursement Arrangement (HRA)
- High Deductible Health Plan (HDHP) with Health Savings Account (HSA)
- Preferred Provider Organization (PPO)
- Health Maintenance Organization (HMO)
- Medicare Advantage Private Fee-for-Service with Prescription Drugs (MA PFFS-PD)

What Should I Do Before I Make My 2009 Benefit Election?

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.

- Evaluate your health care needs
- BlueChoice HMO, Lumenos, Consumer Choice and UnitedHealthcare Indemnity members must make a selection for a NEW option
- If you want to continue with the same coverage you currently have (if offered), you don't have to do anything
- Carefully read this *Retiree Decision Guide* for important information about Plan changes
- Verify that your provider(s) will be participating in the option you choose by calling the Plan option or go to the vendor Web site
- Check the distance you will have to drive to see your provider(s)
- Check Preferred Drug Lists – co-payments or co-insurance
- If you have questions about the options, you may call the Retiree Helpline at: CIGNA Healthcare – (800) 942-6724 or UnitedHealthcare – (877) 246-4190

- If you or your covered spouse are turning age 65, please be sure to carefully read the Medicare information on page 30
- You may make your election online. See below 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
- **Your envelope must be postmarked by November 10, 2008 for your election to be valid. Any forms postmarked after November 10, 2008, will not be processed (NO EXCEPTIONS)**

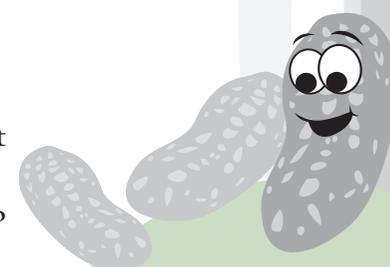
DO NOT RETURN THE ENCLOSED PCF IF YOU MAKE YOUR ELECTION ONLINE OR CHOOSE NOT TO CHANGE YOUR BENEFIT ELECTION.

Reminders

- You should verify that the correct health deduction is taken from each retirement check if you receive any 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 so you can pay the lowest premium

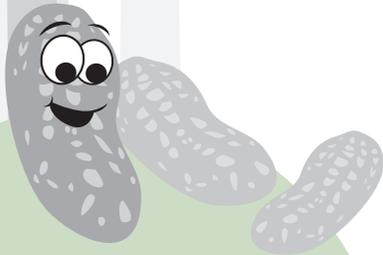
Follow These Steps to Make Your ROCP Election Online

- 1) Go to www.oe2009.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**
5. Review your Medicare information (if available) on the Coverage Selection page. Select your health benefit coverage option



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

Remember you only
have 31 days from the
qualifying event to add or
delete dependents. Don't
miss the deadline waiting
for documentation.



health tip:

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

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, 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
8. This is your confirmation page, which reflects your 2009 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, 2008 will be your benefit election for the 2009 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 2009 as Web traffic may be heavy and exceptions will not be allowed if you were unable to complete your 2009 election. *REMINDER: the Web site will close at 4:30 p.m. EST on November 10, 2008*

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 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 Bluechoice HMO, Bluechoice HMO CCO, Lumenos, Lumenos CCO, or Indemnity options. If you do not go online or complete the PCF to make a new health selection, you will automatically be enrolled in the UnitedHealthcare HRA Option effective January 1, 2009
- If you are enrolled in the Kaiser or UHC Consumer Choice Options (CCO), your coverage will roll over without the Consumer Choice Option
- If you are enrolled in a Kaiser or UHC option, your coverage will roll over to your existing coverage

Health & Wellness

Did You Know?

- Georgia ranks 14th in the U.S. for adult obesity
- Georgia has the 13th highest inactivity rate at 25.9 percent
- Approximately 10 percent (6,700) of Georgians die from obesity each year
- Georgia is in the top 15 states for the highest obesity rates for youths ages 10 through 17
- Approximately 10 percent of adult Georgians have diabetes
- Top three causes of death in Georgia – cardiovascular disease, cancer and stroke

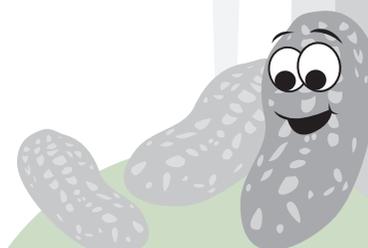
What Can You Do About Your Health?

Take a Personal Health Assessment 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. Personal behaviors that can negatively affect your health can be modified or changed to prevent or reduce the risk of getting certain health conditions/diseases. Members who complete the health assessment may be contacted by the vendor regarding steps you can take to control or eliminate these risks or advise you of tests you may want to consider. You will also be educated on other health coaching services available. Participant data is completely confidential and individual results are not shared with your employer or SHBP. Combined results of all the assessments are used to support and enhance employee health and wellness programs.

Utilize the Preventive Health and Wellness Services One of the best ways to stay healthy is to take advantage of preventive healthcare. Each vendor offers preventive care services. Preventive care is typically defined as periodic health evaluations, such as annual physicals and well-child care, child and adult immunization and screening services, and are subject to national age and gender guidelines; check with the vendor regarding the plan option you choose to confirm which preventive services are covered. Preventive care generally does not include services intended to treat an existing illness, injury or condition or for diagnostic purposes. 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. You may also use your local health department to receive benefit coverage for eligible immunizations/vaccinations.

Engage in the 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 options for additional details on programs offered.

Call the Nurse Advice Line Each vendor has a 24-hour, seven days a week (including holidays) nurse advice line 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.



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!**

Understanding Your Plan Options

To maximize your health benefits, it is more important to 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 this year, you will have two choices for each option listed below. You must select either an option offered by CIGNA Healthcare or UnitedHealthcare.**

shbp tip:

Be on the watch for prize drawings in 2009 for getting your annual physical and completing your health assessment.

Consumer Driven Health Plan Options

The Health Reimbursement Arrangement (HRA) and the High Deductible Health Plan (HDHP) are consumer driven health plan options. These options are structured to provide lower out-of-pocket expenses for many participants and are explained below.

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 PPO 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. The amount in your HRA is used to reduce the deductible and maximum out-of-pocket. After satisfying your deductible, you will pay your coinsurance amount until you reach your out-of-pocket maximum.

Considerations:

- The plan offers unlimited wellness benefits based on age and gender national guidelines when seeing in-network providers only
- There is not a separate deductible and out-of-pocket maximum for out-of-network expenses
- Unused dollars in your HRA account roll over to the next Plan Year if you are still participating in this option
- HRA dollar credits are part of this option only and can only be used with the HRA option
- Unused dollars in the HRA account will be forfeited if you change options during the ROCP or due to a qualifying event
- If you experience a qualifying event and change tiers, your new HRA dollar credits only will be pro-rated based on the number of months remaining in the Plan Year; the deductible and out-of-pocket maximum are not adjusted
- If you experience a qualifying event and change tiers from family to single coverage, your HRA dollars will not be reduced
- 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 Coronary Artery Disease

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

The High Deductible Health Plan (HDHP) design is very similar to that of the PPO 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 18 to compare benefits under the HDHP to other Plan options.

Considerations:

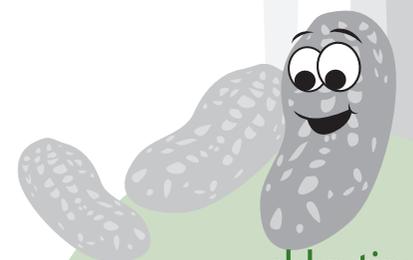
- This option offers 100 percent unlimited wellness benefits based on national age and gender guidelines
- You must satisfy a separate in-network and out-of-network deductible and out-of-pocket maximum
- You pay co-insurance after meeting the entire family deductible for all medical expenses and prescriptions

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 open an HSA with an independent HSA administrator/custodian. Locate HSA Administrators at www.healthsavingsinfo.com/finding.htm.

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 \$3,000 single, \$5,950 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 additional dollars if you are 55 or older (see IRS Publication 502 at www.irs.gov)



shbp tip:

To save money, try over-the-counter brands.

An HRA member with itchy eyes received a doctor's prescription for drops that cost \$82. Her pharmacist helped find \$12 over-the-counter eye drops that did the same thing.

Savings to her HRA – \$82.

(over-the-counter medications are not covered under an HRA.)

Medicare Advantage Private Fee-for-Service with Prescription Drugs (MA PFFS-PD)

A Medicare Advantage Private-Fee-for-Service (MA PFFS) product is an approved plan by the Centers for Medicare and Medicaid Services (CMS) and sometimes called a Medicare Part C Plan. This plan is for retirees and their eligible dependents enrolled in Medicare Parts A and B. This option takes the place of your original Medicare (Part A – Hospital and Part B – Medical Insurance benefits).

This option offers nationwide coverage where members may see any provider willing to accept the Plan's (CIGNA Healthcare or UnitedHealthcare) payment terms, conditions and payment rates. This option provides great flexibility in terms of accessibility to medical providers. Prescription drug coverage is also offered through the Plan's national pharmacy networks.

The MA PFFS-PD option offered by SHBP is a custom option with enriched benefits and is structured to reduce/limit retirees' out-of-pocket expenses.

How does the MA PFFS-PD Option Work (Medical)?

- You can 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)

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, conditions and payment rate 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 under the MA PFFS-PD options
- If your doctor wants to become a Deemed Provider, you or your physician can contact CIGNA Healthcare or UnitedHealthcare directly

How does the MA PFFS-PD Option Work (Prescription Drugs)?

- Most Medicare Part D plans have a deductible and what's called a coverage gap commonly referred to as the "doughnut hole." **SHBP has waived the deductible and will provide benefits through the coverage gap for you.** You will only pay your co-pay amount until you reach the plan's predetermined limit of \$4350.00
- Once you reach the limit you will pay the greater of 5 percent coinsurance or reduced co-pays for generics and brand drugs (\$2.40–\$6.00) for the remainder of the calendar year

Will the MA PFFS-PD cover all of my prescription drugs?

- If you are taking a medication that may require a change (for instance it is not on the approved CIGNA or United Healthcare'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

What if I have Medicare Part A and B and my spouse doesn't?

- You can enroll in one of the MA PFFS-PD options and your spouse will automatically be enrolled in the corresponding HRA option of the vendor you select. You will need to enroll with family coverage in the MA PFFS-PD option

What if my spouse has Medicare Parts A and B and I don't?

- You can enroll your spouse in one of the MA PFFS-PD options and you will automatically be enrolled in the corresponding HRA option by the vendor you select. You will need to enroll with family coverage in the MA PFFS-PD option. The vendor you selected will contact you regarding enrollment in a MA PFFS-PD option once you become eligible

What if I or my spouse are 65 and have Medicare Part A but aren't enrolled in Medicare Part B?

- You may enroll for Medicare Part B during the Medicare annual enrollment period of January 1 – March 31, 2009
- Part B Coverage will then become effective on July 1 of the same year

Isn't there a penalty if I didn't enroll for Part B when I first became eligible?

- Yes. However, the SHBP will pay the penalties on your behalf

Can I enroll in the MA PFFS-PD plan now if I or my spouse doesn't have Medicare Part B?

- No, but you can when you obtain Medicare Part B coverage

Considerations:

- Must have Medicare Parts A and B
- To enroll in the MA PFFS-PD you must make your election online or via paper and submit to SHBP. The MA PFFS-PD will mail you an application you will need to complete
- Prescription drugs are included; you do not need to purchase a separate Part D plan
- If you have purchased Part D on your own, it will automatically be cancelled if you enroll in an SHBP sponsored MA PFFS-PD
- If you are covered by the SHBP MA PFFS-PD option and elect to enroll in a Medicare Part D plan, your coverage in the MA PFFS-PD option will end
- Low out-of-pocket expenses
- Must seek services from a Deemed Provider that accepts UnitedHealthcare or CIGNA Healthcare's terms, conditions and payment rates
- No filing of claims with Medicare or coordination of benefits

Preferred Provider Organization (PPO)

A Preferred Provider Organization (PPO) allows 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. No election of a primary care physician or referral to a specialist is required. This option requires that you satisfy a deductible with coinsurance and has an out-of-pocket maximum (OOP). When you meet the maximum, the PPO pays your covered services at 100 percent of the allowed amount; however, you will continue to pay your co-pays.

Considerations:

- Out-of-network benefits are paid at 60 percent with 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
- You must satisfy a separate in-network and out-of-network deductible and separate out-of-pocket maximum

Health Maintenance Organization (HMO)

A Health Maintenance Organization (HMO) allows you to receive 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 page 18 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)
- Co-payments do not count toward your deductible or out-of-pocket maximum
- Both CIGNA Healthcare and UnitedHealthcare HMO options provide a national network and services are paid at the same benefit levels when using network providers outside of Georgia
- Maintenance medications require only two co-pays for a 90-day supply when received at a retail pharmacy

shbp tip:

While not required, we strongly encourage you to select a PCP to assist in the overall coordination of care.

SHBP Eligibility

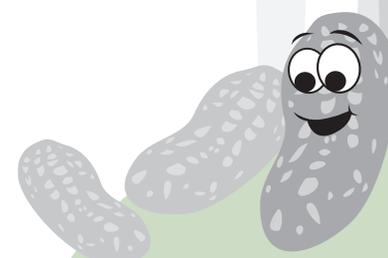
The SHBP covers dependents who meet SHBP guidelines and requires eligibility documentation before SHBP can send dependents' notification of coverage to the health plans.

Eligible dependents are:

- **Your legally married spouse**, as defined by Georgia Law
- **Your never-married dependent children who are:**
 1. **Natural or legally adopted children under age 19**, unless they are eligible for coverage as employees. Children that are legally adopted through the judicial courts become eligible only after they are placed in your physical custody
 2. **Stepchildren under age 19 who live with you** at least 180 days per year and for whom you can provide documentation satisfactory to the Plan that they are your dependents
 3. **Other children under age 19** if they live with you permanently and legally depend on you for financial support – as long as you have a court order, judgment or other satisfactory proof from a court of competent jurisdiction
 4. **Your natural children, legally adopted children or stepchildren** who are physically or mentally disabled prior to reaching age 26 and who depend on you for primary support
 5. **Your natural children, legally adopted children, 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:

If your child is turning 19 and is a full-time student or disabled, you may be able to continue his/her coverage, provided you submit the proper documentation.

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 SPD. You can contact the Eligibility Unit for assistance at 800-610-1863 or in the Atlanta area at 404-656-6322.

Qualifying events include, but are not limited to:

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

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

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.



health tip:

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

Benefits Comparison

Schedule of Benefits for You and Your Dependents for January 1, 2009 – December 31, 2009

	PPO OPTION		HRA OPTION	
	In-network CIGNA Healthcare, UnitedHealthcare	Out-of-network CIGNA Healthcare, UnitedHealthcare	In-network CIGNA Healthcare, UnitedHealthcare	Out-of-network CIGNA Healthcare, UnitedHealthcare
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		Not applicable	
Lifetime Benefit Limit for Treatment of: (combined for PPO Option and HDHP) • Temporomandibular joint dysfunction (TMJ)	\$1,100		\$1,100	
Deductibles/Co-Payments: • Employee • Employee + Spouse + Child(ren) • Hospital deductible per admission for Medical and Behavioral Health	\$500 \$1,500	\$1,000 \$3,000	\$1,000* \$2,500* <i>*HRA credits will reduce this amount.</i>	Not applicable
Out-of-Pocket Maximum: • Retiree • Family	\$1,500 + co-pays \$3,000 + co-pays	\$3,000 + co-pays \$6,000 + co-pays	\$2,000* \$4,500* <i>HRA credits will reduce this amount.</i>	
HRA Credits: • Retiree • Family	None		\$500 \$1,500	
Physicians' Services				
Primary Care Physician or Specialist Office or Clinic Visits: Treatment of illness or injury	\$30 per office visit co-payment; subject to deductible for associated lab and x-ray	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)	\$30 co-payment per office visit; No co-payment for associated tests and immunizations. Maximum of \$1,000 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, 2009 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	MA PFFS-PD
In-network CIGNA Healthcare, UnitedHealthcare	Out-of-network CIGNA Healthcare, UnitedHealthcare	CIGNA Healthcare, UnitedHealthcare	CIGNA Healthcare, UnitedHealthcare
<i>The Plan Pays:</i>		<i>The Plan Pays:</i>	<i>The Plan Pays:</i>
\$2 million		\$2 million	Not applicable
Not applicable		Not applicable	Not applicable
\$1,100		No separate lifetime benefit limit	Contact plans for details
\$1,150 \$2,300	\$2,300 \$4,600	\$400 \$800	Not applicable Not applicable
Not applicable		Not applicable	
\$1,700 \$2,900	\$3,800 \$7,000	\$1,500 + co-pays \$3,000 + co-pays	\$1,000 per member
None		None	None
90% coverage; subject to deductible	60% coverage; subject to deductible	\$30 per office visit co-payment	Primary—\$20 per office visit co-payment; Specialist—\$25 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 \$30 for primary care and specialty care; No co-payment for immunizations and mammograms	Primary—\$20 per office visit co-payment; Specialist—\$25 per office visit co-payment

	PPO OPTION		HRA OPTION	
	In-network CIGNA Healthcare, UnitedHealthcare	Out-of-network CIGNA Healthcare, UnitedHealthcare	In-network CIGNA Healthcare, UnitedHealthcare	Out-of-network CIGNA Healthcare, UnitedHealthcare
Physicians' Services	<i>The Plan Pays:</i>		<i>The Plan Pays:</i>	
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
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 in-network deductible		90% coverage; subject to in-network 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; subject to deductible	90% coverage; subject to deductible	60% coverage; 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 \$100 per visit co-payment; co-payment waived if admitted; subject to in-network deductible		90% coverage; subject to deductible	

HIGH DEDUCTIBLE OPTION (HDHP)		HMO OPTIONS	MA PFFS-PD
In-network CIGNA Healthcare, UnitedHealthcare	Out-of-network CIGNA Healthcare, UnitedHealthcare	CIGNA Healthcare, UnitedHealthcare	CIGNA Healthcare, UnitedHealthcare
<i>The Plan Pays:</i>		<i>The Plan Pays:</i>	<i>The Plan Pays:</i>
90% coverage; subject to deductible	60% coverage; subject to deductible	100% after initial \$30 co-payment	\$0 co-payment after initial Specialist co-payment of \$25
90% coverage; subject to deductible	60% coverage; subject to deductible	90% coverage; subject to deductible	100% coverage, hospital facility co-payment will apply
90% coverage; subject to deductible		100% (\$100 co-pay applies to facility expenses)	100% coverage, facility co- payment will apply
90% coverage; subject to deductible	60% coverage; subject to deductible	100% after \$30 co-payment if billed as office visit	Primary – \$20 per office visit co-payment; Specialist – \$25 per office visit co-payment
90% coverage; subject to deductible	60% coverage; subject to deductible	90% coverage; subject to deductible	100% coverage, facility co- payment will apply
90% coverage; subject to deductible	60% coverage; subject to deductible	100% for shots and serum after a \$30 per visit co-payment; No co-pay if office visit not billed	Primary—\$20 per office visit co-payment; Specialist—\$25 per office visit co-payment 90% coverage of serum if billed separately
90% coverage; subject to deductible	60% coverage; subject to deductible	90% coverage; subject to deductible	\$190 per day co-payment for days 1–4, \$0 co-payment per day for days 5 and beyond
90% coverage; subject to deductible	60% coverage; subject to deductible	100% coverage not subject to deductible	Not covered
90% coverage; subject to deductible	60% coverage; subject to deductible	90% coverage; subject to deductible	100% coverage after \$95 co-payment
90% coverage; subject to in-network deductible		100% after a \$100 per visit co-payment; if admitted co-payment waived; subject to deductible	\$50 co-payment (waived if admitted within 24 hours)

	PPO OPTION		HRA OPTION	
	In-network CIGNA Healthcare, UnitedHealthcare	Out-of-network CIGNA Healthcare, UnitedHealthcare	In-network CIGNA Healthcare, UnitedHealthcare	Out-of-network CIGNA Healthcare, UnitedHealthcare
Outpatient Testing, Lab, etc.	<i>The Plan Pays:</i>		<i>The Plan Pays:</i>	
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
Behavioral Health				
Mental Health and Substance Abuse Inpatient Facility and Partial Day Hospitalization NOTE: All services require prior authorization except MA PFFS-PD	90% coverage; subject to deductible	60% coverage; subject to deductible	90% coverage; subject to deductible	60% coverage; subject to deductible
Mental Health and Substance Abuse Outpatient Visits and Intensive Outpatient NOTE: All services require prior authorization except MA PFFS-PD	90% coverage; subject to deductible; \$30 co-payment for office visit	60% coverage; subject to deductible	90% coverage; subject to deductible	60% coverage; subject to deductible
Dental				
Dental and Oral Care NOTE: Coverage for most procedures for the prompt repair of sound natural teeth or tissue for the correction of damage caused by traumatic injury.	90% coverage; subject to deductible	60% coverage; subject to deductible	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 NOTE: Limited to one eye exam every 24 months	90% coverage; not subject to deductible	Eye exam not covered	100% coverage; not subject to deductible	Eye exam not covered
Other Coverage				
Hearing Services	Not covered		90% coverage for routing exam and fitting; subject to deductible; \$1,500 hearing aid allowance every 5 years	
Ambulance Services for Emergency Care NOTE: “Land or air ambulance” to nearest facility to treat the condition.	90% coverage; subject to in-network deductible		90% coverage; subject to in-network deductible	
Urgent Care Services NOTE: All subject to deductible except HMO and MA PFFS-PD	90% coverage after a \$45 per visit co-payment	60% coverage	90% coverage	60% coverage

HIGH DEDUCTIBLE OPTION (HDHP)		HMO OPTIONS	MA PFFS-PD
In-network CIGNA Healthcare, UnitedHealthcare	Out-of-network CIGNA Healthcare, UnitedHealthcare	CIGNA Healthcare, UnitedHealthcare	CIGNA Healthcare, UnitedHealthcare
<i>The Plan Pays:</i>		<i>The Plan Pays:</i>	<i>The Plan Pays:</i>
90% coverage; subject to deductible	60% coverage; subject to deductible	90% coverage; subject to deductible; office or independent lab/ x-ray 100% coverage	\$0 co-payment for diag- nostic test/lab services and Medicare covered standard x-rays; \$25 co-payment for complex radiology services and imaging procedures
90% coverage; subject to deductible	60% coverage; subject to deductible	UHC—90% coverage; not subject to deductible. CIGNA—90% coverage subject to deductible	\$190 co-payment per day for days 1–4, \$0 co-payment for days 5–190. 190 day lifetime maximum; \$60 co-payment per day for partial hospitalization
90% coverage; subject to deductible	60% coverage; subject to deductible	100% after \$30 per visit co-payment. \$10 co-payment for group therapy	\$25 per office visit co- payment; Intensive Outpatient—\$60 co-pay- ment per visit
90% coverage; subject to deductible	60% coverage; subject to deductible	100% after \$30 per visit co-payment; if inpatient/ outpatient facility, 90% subject to deductible	\$25 per office visit co-pay- ment for covered medical services
NOTE: Notification required for all UHC options.			
90% coverage; subject to deductible	60% coverage; subject to deductible	100% after \$30 co-payment for related surgery and diagnostic services; excludes appliances and orthodontic treatment; if inpatient/ outpatient facility, 90% subject to deductible	Contact plans for details
90% coverage; not subject to deductible	Eye exam not covered	100% after \$30 co-payment; not subject to deductible. \$200 annual benefit for glasses and contacts	\$25 co-payment per office visit—limited to 1 annual eye exam; \$125 eyewear (glasses, contact lenses and frames) allowance every 2 years
90% coverage for routing exam and fitting; subject to deductible; \$1,500 hearing aid allowance every 5 years		Not covered	\$25 co-payment for each covered diagnostic and/or routine hearing exam; limited to 1 annual test; \$1,000 hear- ing aid allowance every 4 years
90% coverage; subject to in-network deductible		100% coverage; not subject to deductible	100% coverage
90% coverage	60% coverage	100% after \$35 co-payment	\$25 co-payment

	PPO OPTION		HRA OPTION	
	In-network CIGNA Healthcare, UnitedHealthcare	Out-of-network CIGNA Healthcare, UnitedHealthcare	In-network CIGNA Healthcare, UnitedHealthcare	Out-of-network CIGNA Healthcare, UnitedHealthcare
Other Coverage	<i>The Plan Pays:</i>		<i>The Plan Pays:</i>	
Home Health Care Services NOTE: Prior approval required	90% coverage; subject to deductible	60% coverage; subject to deductible	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 NOTE: Prior approval required for certain DME	90% coverage; subject to deductible	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
Foot Care	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.	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*	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	MA PFFS-PD
In-network CIGNA Healthcare, UnitedHealthcare	Out-of-network CIGNA Healthcare, UnitedHealthcare	CIGNA Healthcare, UnitedHealthcare	CIGNA Healthcare, UnitedHealthcare
<i>The Plan Pays:</i>		<i>The Plan Pays:</i>	<i>The Plan Pays:</i>
90% coverage; subject to deductible	60% coverage; subject to deductible	100% coverage; up to 120 visits per Plan Year	100% coverage—unlimited (no prior approval required)
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	\$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 approval required)
90% coverage; subject to deductible	60% coverage; subject to deductible	100% coverage; subject to deductible	100% coverage (must receive care from a Medicare covered hospice facility; no prior approval required)
90% coverage; subject to deductible	60% coverage; subject to deductible	100% coverage when medically necessary	90% coverage for Medicare covered items (no prior approval required)
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	\$25 co-payment per office visit; no limit on number of visits
90% coverage; subject to deductible	60% coverage; subject to deductible	100% coverage after \$30 co-payment per visit	Medicare Covered —\$25 co-payment per office visit Routine Non Medicare Covered —United: \$25 co-payment per office visit; limited to 20 visits per year; CIGNA: Not covered
90% coverage; subject to deductible	60% coverage; subject to deductible	100% coverage after \$30 co-payment per visit	\$25 per office visit co-payment; Routine Non Medicare Covered —limit 6 annual visits
90% coverage at contracted transplant facility; subject to deductible	Not covered	90% coverage; subject to deductible	\$190 co-payment per day for days 1–4, \$0 co-payment per day for days 5 and beyond
80% coverage; subject to deductible \$10 min./\$100 max.	Not covered	\$10	*\$10 retail/\$20 Mail order 90 day supply
80% coverage; subject to deductible \$10 min./\$100 max.	Not covered	\$30	*\$25 retail/\$50 Mail order 90 day supply
80% coverage; subject to deductible \$10 min./\$100 max.	Not covered	\$75	*\$50 retail/\$100 Mail order 90 day supply
Not applicable	Not covered	Not covered	*\$50 retail/\$100 Mail order 90 day supply; Medicare Part B Covered Drugs—90% coverage

decision guide 2009

*Includes a Medicare approved Part D drug benefit; After total yearly out-of-pocket costs reach \$4,350 you pay the greater of \$2.40 for generic or a preferred brand drug and \$6 for all other drugs or 5% co-insurance.

State Health Benefit Plan

Medicare Policy

- Georgia law requires that SHBP pay benefits after Medicare has paid
- SHBP will calculate premiums and pay claims 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
- 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)
- 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, 2008. 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

Retirees have the same options as active employees as well as the two Medicare Advantage Private Fee-for-Service Plans for Prescription Drugs (MA PFFS-PD). The MA PFFS-PD Plans have been designed to reduce the out-of-pocket expenses for retirees with Medicare Parts A and B.

If you enroll in one of the MA PFFS-PD options once retired, you do not need to join an individual Medicare Part D plan as these options include Part D.

You are not required to enroll in one of the MA PFFS-PD options; however, to pay the lowest premiums with SHBP, you may want to consider enrolling in Medicare Parts A, B and D.

If you elect to enroll in another Medicare Part D plan, your coverage in the MA PFFS option will end. To enroll in a SHBP-sponsored MA PFFS-PD, you must make your election on the Personalized Change Form and submit to SHBP. The MA PFFS option will mail you an application that you will need to complete.

If you are enrolled in Medicare Parts A or Part B, you are eligible for Part D. SHBP will provide secondary coverage to Medicare prescription drug plans. In many cases, a basic Part D plan will meet your needs as SHBP will pay benefits during any deductible and the “donut hole” that may apply under your Part D option.

Your individual pharmacy needs will determine the level of coverage that is best for you.

More detailed information can be found in this *Retiree Decision Guide* or at www.dch.georgia.gov/shbp_plans.

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. SHBP does not fund these accounts.
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.



GEORGIA DEPARTMENT OF
COMMUNITY HEALTH

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

October 1, 2008

About Your Prescription Drug Coverage with PPO, United Healthcare HMO, UnitedHealthcare Definity, Kaiser Permanente, CIGNA Healthcare Open Access Plus PPO, CIGNA Healthcare Open Access Plus In-Network HMO, CIGNA Healthcare Choice Fund HRA and Medicare

For Plan Year: January 1–December 31, 2009

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.

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 State Health Benefit Plan has determined that the prescription drug coverage offered by the UnitedHealthcare PPO, United Healthcare HMO, UnitedHealthcare Definity, Kaiser Permanente, CIGNA Healthcare Open Access Plus PPO, CIGNA Healthcare Open Access Plus In-Network HMO, CIGNA Healthcare Choice Fund 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, 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 SHBP coverage voluntarily, 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 State Health Benefit Plan coverage will be affected. See below for more information about what happens to your current coverage if you join a Medicare drug plan. You can keep your SHBP coverage if you elect Part D and SHBP will coordinate with Part D coverage. 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 38342, Atlanta, GA 30334.

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

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 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.

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, 2008

Name of 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



GEORGIA DEPARTMENT OF
COMMUNITY HEALTH

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

October 1, 2008

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

About Your Prescription Drug Coverage with the CIGNA Healthcare Open Access Plus and UnitedHealthcare High Deductible Health Plan and Medicare

For Plan Year: January 1–December 31, 2009

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 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 good as the 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 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 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.

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 percent 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 percent 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'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, 2008

Name of 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

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

Penalties for Misrepresentation

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

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

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.



**GEORGIA'S NUTS
ABOUT HEALTH!**

Thanks to all of you who participated in the State Health Benefit Plan's "Georgia's Nuts About Health" wellness initiative. It's never too late to be healthy!
www.nutsabouthealth.ga.gov



GEORGIA DEPARTMENT OF
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