

New Employee Decision Guide 2009

GEORGIA'S NUTS ABOUT HEALTH!

Steps to Maintain Good Health:

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



Phone Numbers/Contact Information

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

Vendor	Member Services	Pharmacy	Web Site
UnitedHealthcare			
Definity HRA	800-396-6515		www.myuhc.com/groups/gdch
HDHP	877-246-4195 TDD 800-842-5754	800-372-5802	www.myuhc.com/groups/gdch
CIGNA Healthcare			
HRA, HDHP	800-633-8519 TDD 800-576-1314	800-633-8519	www.cigna.com/shbp
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

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

Disclaimer: 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.

The Summary Plan Description (SPD) for each Plan option is posted on the DCH Web site, www.dch.georgia.gov/shbp_plans. You may print or request a paper copy by calling the Customer Service number on the back of your ID card. Please keep your 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

December 1, 2008

Dear New State Health Benefit Plan Member:

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

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

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

Each plan's design is similar to that of a PPO with in-network and out-of-network benefits, wellness benefits, and other enhanced benefits exclusive to the HRA and HDHP plans.

SHBP offers an annual open enrollment period for all employees. You will be able to select from the consumer driven health options **in addition to** two Preferred Participating Organization (PPO) options, and two Health Maintenance Organization (HMO) options during the 2009 open enrollment period. You can access information about these options at www.dch.georgia.gov/shbp_plans.

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

Sincerely,

Rhonda M. Medows, M.D.

Equal Opportunity Employer

SHBP Acronyms

DCH – Georgia Department of Community Health
CDHP – Consumer Driven Health Plan
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
SHBP – State Health Benefit Plan
SPD – Summary Plan Description
UHC – UnitedHealthcare
EE – Employee
ES – Employee + Spouse
EC – employee + Child(ren)
EF – Employee + Child(ren) + Spouse

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Health & Wellness

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

- **Health Assessments** – each SHBP vendor has a 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 your 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 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

State Health Benefit Plan

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

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

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

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

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

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

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

Steps you can take include:

- Keep a list of all medications you take
- Shop in-network providers and pharmacies
- Find out what your drugstore charges for a drug
- Make sure all procedures are pre-certified, if required
- Make sure you get the results of any test or procedure
- Understand what will happen if you need surgery
- Check your Explanation of Benefits (if provided under your plan option) and if something does not make sense or seems to cost too much, ask your provider about it

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

Eligibility Information

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

For You

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

- **A full-time employee of the state of Georgia, the Georgia General Assembly, or an agency, board, commission, department, county administration or contracting employer that participates in the SHBP, as long as:**

- You work at least 30 hours a week consistently, and
- Your employment is expected to last at least nine months.

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

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

Not Eligible: Temporary or emergency employees

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

For Your Dependents

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

Eligible dependents are:

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

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

Documentation Confirming Eligibility for Your Spouse or Dependents

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

Acceptable documentation:

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

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

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



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.

Please note:

- The employee's Social Security Number must be written on each document so we can match your dependents to your record
- Do not send original documents as no documents will be returned to you
- SHBP will allow members to submit verification of their dependent's eligibility any time during the Plan Year; however, no claims will be paid until the documentation is received and approved by SHBP

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 prior to or within 31 days after 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

General Information and Enrollment

Before You Enroll

You should:

- Read the current *Decision Guide* and SPD to understand your Health Plan Options prior to making your health election
- Contact your employer or payroll location Benefit Coordinator for assistance if you have benefit questions or you may go to www.dch.georgia.gov/shbp_plans
- Read and understand the SHBP Tobacco and Spousal Surcharge Policies, and answer all questions regarding these surcharges. If you fail to answer the questions, the surcharge(s) will apply for the 2009 Plan Year unless you experience a qualifying event
- Gather eligibility verification documents for all dependents for whom coverage has been requested to submit within the required time frame
- Understand the election you make will be valid for the 2009 Plan Year unless you experience a qualifying event
- Additional options will be available to you during the Fall Open Enrollment for coverage effective January 1, 2010

Health Benefit Cost Estimators

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

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

Access the links to the PCE tools at the DCH Web site, www.dch.georgia.gov/shbp_plans.

How to Enroll

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

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

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

1. Your coverage options:

CIGNA Healthcare

- CIGNA Choice Fund (HRA)
- High Deductible Health Plan (HDHP)*

UnitedHealthcare

- Definity (HRA)
- High Deductible Health Plan (HDHP)*

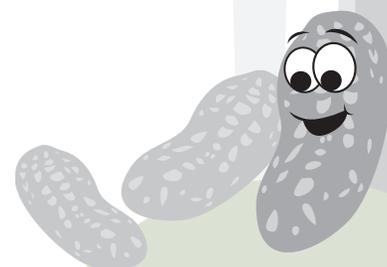
**These options allow you to set up a Health Savings Account. See page 12 for more information.*

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

3. Which coverage tier? Select the coverage tier you desire for the dependents that you choose to cover. You will be locked into the tier for the 2009 Plan Year unless you experience a qualifying event.

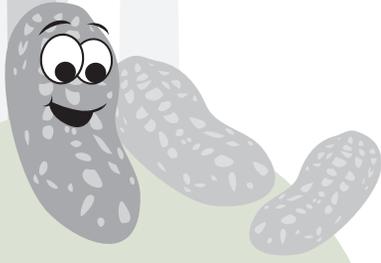
- EE = Employee
- EC = Employee + Child(ren)
- ES = Employee + Spouse
- EF = Employee + Child(ren) + Spouse

NOTE: Additional options will be available to you during the Fall Open Enrollment period for coverage effective January 1, 2010.



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.

What Happens if I Have Other Insurance?

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

When SHBP benefits are coordinated, the SHBP does not pay more than 100 percent of the allowed amount. Non-covered services or items, penalties and amounts balance billed are not part of the allowed amount and are the member's responsibility.

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

COBRA Rights

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

Surcharge Policy

You should be aware that SHBP charges a Tobacco and Spousal Surcharge. A \$40 tobacco surcharge will be added to your monthly premium if you or any of your covered dependents have used tobacco products in the previous 12 months. A \$30 spousal surcharge will be added to your monthly premium if you have elected to cover your spouse and your spouse is eligible for coverage through his/her employment but chose not to take it. If your spouse is eligible for coverage with SHBP through his/her employment, the spousal surcharge will be waived.

You will automatically be charged the applicable surcharges if you fail to answer all questions concerning the surcharges. The surcharges will apply to your premium until the next Plan Year.

How to Remove Surcharges

Tobacco

You may have the tobacco surcharge removed if:

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

Spousal

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

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

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

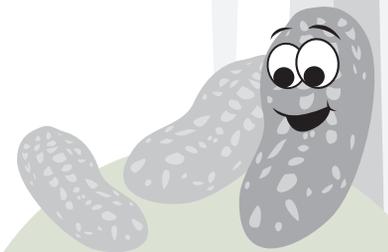
State Health Benefit Plan Medicare Policy and Retirement

Federal Law requires SHBP to pay primary benefits for active employees and their dependents. Active members or their covered dependents may choose to delay Medicare enrollment. Termination of active employment is a qualifying event for enrolling in Medicare without penalty (except HDHP, see page 18).

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

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

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



health tip:

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

Understanding Your Plan Options

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

Important Terms to Understand

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

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

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

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

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

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

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

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

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

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

shbp tip:

Be on the watch for prize drawings in 2009 for completing your health assessment.

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, you will have a total of four choices. You must select either an option offered by CIGNA Healthcare or UnitedHealthcare. During next Open Enrollment, you may have additional options available. Information is available at www.dch.ga.gov/shbp_plans**

Consumer Driven Health Plan Options

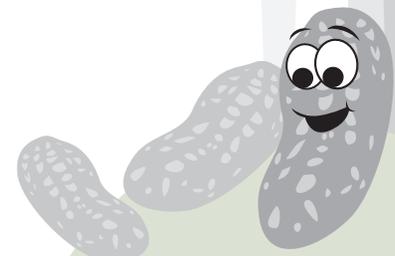
The Health Reimbursement Arrangement (HRA) and the High Deductible Health Plan (HDHP) are consumer driven health plan options. These options are structured to provide lower out-of-pocket expenses for many participants and are explained below. Participation in these options impacts your eligibility and the amount you can contribute to a FSA. Additional information to assist you with understanding the rules and differences can be found on page 17 of this *Decision Guide*.

Health Reimbursement Arrangement (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 a 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, at which time SHBP will pay 100 percent of eligible expenses for the remainder of the Plan Year.

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 co-insurance 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 to a non HRA option during the Open Enrollment, a qualifying event occurs, or you terminate employment; even if you re-enroll in a subsequent Plan Year
- 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, 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 another tier, your HRA dollars will not be reduced
- Certain drug costs are waived if you participate in one of the Disease State Management Programs (DSM) for Diabetes, Asthma and Coronary Artery Disease



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 drops that did the same thing. **Savings to her HRA – \$70.**

High Deductible Health Plan with a Health Savings Account

The High Deductible Health Plan (HDHP) design is very similar to that of a 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 13 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

An HSA is like a personal savings account with investment options for health care, except it's all tax-free. You may be eligible to participate in an HSA that is offered through the State of Georgia Flexible Benefits Program or by your employer. Participation through payroll deductions allows your contributions to be pre-tax. If your employer does not offer an HSA, you may still open an HSA with an independent HSA administrator/custodian. You may 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) FSA also known as the General Purpose Flexible Spending Account (GPFSA), or a General Purpose Health Care Spending Account or 5) any other non-qualified medical plan.

- You can make contributions to a State of Georgia HSA only when enrolled in the SHBP HDHP
- 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)
- HSA accounts cannot be combined with a FSA also known as a General Purpose Healthcare Spending Account (GPHCSA), but can be combined with a limited purpose flexible spending account. Contact the State Personnel Administration or your employer
- You can contribute additional dollars if you are 55 or older (see IRS Publication 502 at www.irs.gov)

Benefits Comparison

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

Covered Services	HIGH DEDUCTIBLE 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
	<i>The Plan Pays:</i>		<i>The Plan Pays:</i>	
Deductibles:				
EE = Employee	\$1,150	\$2,300	\$1,000*	
ES = Employee + Spouse	\$2,300	\$4,600	\$1,750*	
EC = Employee + Child(ren)	\$2,300	\$4,600	\$1,750*	
EF = Employee + Spouse + Child(ren)	\$2,300	\$4,600	\$2,500*	
			<i>*HRA credits will reduce this amount.</i>	
Out-of-Pocket Maximum:				
EE = Employee	\$1,700	\$3,800	\$2,000*	
ES = Employee + Spouse	\$2,900	\$7,000	\$3,250*	
EC = Employee + Child(ren)	\$2,900	\$7,000	\$3,250*	
EF = Employee + Spouse + Child(ren)	\$2,900	\$7,000	\$4,500*	
			<i>*HRA credits will reduce this amount.</i>	
HRA Credits:				
EE = Employee			\$500	
ES = Employee + Spouse			\$1,000	
EC = Employee + Child(ren)		None	\$1,000	
EF = Employee + Spouse + Child(ren)			\$1,500	
Maximum Lifetime Benefit (combined for all SHBP Options)	\$2 million		\$2 million	
Pre-Existing Conditions, Limitations or Exclusions (First year in Plan only, subject to HIPAA)	None		None	
Lifetime Benefit Limit for Treatment of: (combined for PPO Option and HDHP) • Temporomandibular joint dysfunction (TMJ)	\$1,100		\$1,100	
Physicians' Services				
Primary Care Physician or Specialist Office or Clinic Visits: Treatment of illness or injury	90% coverage; subject to deductible	60% coverage; subject to deductible	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% coverage; not subject to deductible	Not covered; Charges do not apply to deductible or annual out-of-pocket limits	100% coverage; not subject to deductible	Not covered; Charges do not apply to deductible or annual out-of-pocket limits

*HMO and PPO options will be available at the next Open Enrollment period.

	HIGH DEDUCTIBLE 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; subject to deductible	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 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	90% coverage; subject to deductible	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; subject to deductible	60% coverage; subject to deductible	90% coverage; subject to deductible	60% coverage; subject to deductible
• Well-newborn care	90% coverage; 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; subject to in-network deductible		90% coverage; subject to deductible	

	HIGH DEDUCTIBLE 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.	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	90% coverage; subject to deductible	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
Temporomandibular Joint Syndrome (TMJ) NOTE: Coverage for diagnostic testing and non-surgical treatment up to \$1,100 per person lifetime maximum benefit.	90% coverage; subject to deductible	60% coverage; subject to deductible	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				
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 deductible	
Urgent Care Services	90% coverage; 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

	HIGH DEDUCTIBLE 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>	
Skilled Nursing Facility Services NOTE: 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	Not covered
Hospice Care NOTE: Prior approval required	90% 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	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 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)	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; subject to deductible	60% coverage; subject to deductible	90% coverage; subject to deductible	60% coverage; subject to deductible
Transplant Services NOTE: Prior approval required.	UHC – 90% coverage at a designated transplant facility; Subject to deductible ----- CIGNA – 100% at Lifesource Centers otherwise 90%; subject to deductible	Not covered ----- CIGNA – No coverage	UHC – 90% coverage at a designated transplant facility; Not subject to deductible ----- CIGNA – 100% at Lifesource Centers otherwise 90%; not subject to deductible	60% coverage; subject to deductible ----- CIGNA – No coverage
Pharmacy				
Tier 1 Co-payment NOTE: No Tiers in HRA Option	80% coverage; subject to deductible \$10 min. /\$100 max.	Not covered	90% coverage; subject to deductible	60% coverage; subject to deductible
Tier 2 Co-payment	80% coverage; subject to deductible \$10 min. /\$100 max.	Not covered		
Tier 3 Co-payment	80% coverage; subject to deductible \$10 min. /\$100 max.	Not covered		

HRA, HSA and Flexible Spending Account (FSA) Considerations

HRA and HSA participation impacts your eligibility and amount of dollars you can contribute to a FSA, also known as a Healthcare Spending Account. This chart highlights the rules and differences.

	HRA	HSA
Overview	<p>A tax-exempt account that is funded for qualified medical expenses. Can be funded by employer only.</p> <hr/> <p>Available to SHBP members enrolled in an HRA. The benefits chart for amounts funded by SHBP.</p>	<p>A tax-exempt custodial account that exclusively pays for qualified medical expenses of the employee and his or her dependents. Can be funded by employee, employer, or other party.</p> <hr/> <p>Available to SHBP members who elect HDHP. An HSA is available under the Flexible Benefits Program, offered through the State Personnel Administration, your employer, or you may participate as an individual. SHBP does not fund these amounts.</p>
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.
Can I participate in a Flexible Spending Account?	You may enroll in a General Purpose Flexible Spending Account. You may use a FSA for uncovered or unreimbursed portions of qualified medical costs.	You may enroll in a Limited Purpose FSA covering dental and vision if you are enrolled in a Health Savings Account.
Who owns the money in these accounts?	SHBP. Money reverts back to SHBP upon loss of SHBP HRA coverage.	The employee.
Can these dollars be rolled over each year?	Yes.	Yes.
Is there a monthly service charge?	No.	Yes, \$3.00 per account per month with the SPA Flexible Benefits Program. For other HSA accounts check with your HSA administrator.
What is the order in using these accounts?	HRA must be used before using the FSA.*	Can only use Limited Purpose FSA with the HSA, but it doesn't matter which is used first.
Can I take it with me?	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.

*When determining how much money to set aside in an FSA, employees should consider the first \$500 (employee) or \$1,000 {employee + spouse OR employee + child(ren) OR \$1,500 (employee + spouse + child(ren)) of qualified medical expenses will be covered by the HRA.



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 cop

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 State Health Benefit Plan (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 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



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

Annual Legal Notices (No Action Required)

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
- Protheses 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.

Statement of Rights under the Newborns' and Mothers' Health Protection Act

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

Health Insurance 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 State Health Benefit Plan (SHBP) coverage.

The PPO Option contains a pre-existing condition (PEC) limitation. Specifically, the Health Plan will not pay charges that are over \$1,000 for the treatment of any pre-existing condition during the first 12 months of a patient's coverage, unless the patient gives satisfactory documentation that he or she has been free of treatment or medication for that condition for at least six consecutive calendar months. However, a PEC 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 members and dependents can reduce the 12-month PEC limitation period. The reduction is possible by using what is called "creditable coverage" to offset a PEC period. Creditable coverage generally includes the health coverage you or a family member had immediately prior to joining the SHBP. Coverage under most group health plans, as well as coverage under individual health policies and governmental health programs, qualifies as creditable coverage.

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

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

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

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



GEORGIA DEPARTMENT OF
COMMUNITY HEALTH

Rhonda M. Medows, MD, Commissioner

Sonny Perdue, Governor

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

November 1, 2008

TO: All Members of the State Health Benefit Plan

Under a federal law known as the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”), certain notices must be provided to you. This letter will serve as notice to you related to the surcharge for tobacco use that the Plan will charge for coverage January 1, 2009. This memo will also serve as notice to you that the State Health Benefit Plan, (“SHBP”) has elected to exempt SHBP from the Special enrollment periods.

Under HIPAA, group health plans may not discriminate on the basis of “health status.” However, the law also permits state and local government employers that sponsor health plans to elect to exempt a plan from this requirement for any plan that is “self-funded” by the employer, rather than provided through a private health insurance policy. The Department of Health and Human Resources considers tobacco use to be a “health status.” Therefore, the self-funded options under the SHBP have opted out of this requirement for the plan year January 1, 2009 through December 31, 2009. The election may be renewed for subsequent plan years. The purpose of this exemption is to enable the SHBP to comply with federal law in applying the tobacco use surcharge.

Therefore, this notice informs all members of the self-funded options of the SHBP of the Plan’s election to be exempt from the following provision:

Prohibitions against discriminating against individual participants and beneficiaries based upon health status. A group health plan may not discriminate in enrollment rules or in the amount of premiums or contributions; it requires an individual to pay based on certain health status-related factors: health status, medical condition (physical and mental illnesses), claims experience, receipt of health care, medical history, genetic information, evidence of insurability, and disability.

The exemption and this notice to not change your eligibility, your benefits, or your premiums, other than to apply the surcharge for tobacco use, if applicable.

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

The SHBP elects to be exempt from Special enrollment periods. Group health plans are required to provide special enrollment periods for individuals who do not enroll in the plan because they have other coverage, but subsequently lose that coverage. Also, if a plan provides dependent coverage, the plan must provide a special enrollment for new dependents (and the employee is not already enrolled) within 30 days after a marriage birth, adoption or placement for adoption. As a self-funded non-federal governmental group health plan, the SHBP of the Georgia Department of Community Health (“DCH”) elects to opt-out of this option.

If you have any questions about this notice, you may contact:

State Health Benefit Plan
Attn: Surcharge
P. O. Box 38342
Atlanta, GA 30334



GEORGIA DEPARTMENT OF
COMMUNITY HEALTH

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

October 1, 2008

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

Your employer (state agency, school system authority, etc.) sent information about you to DCH. This information included your name, address, birth date, phone number, Social Security Number, gender and other health insurance policies that you may have. 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 HIPAA Privacy Notices. This notice is 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 healthcare 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 healthcare 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 30303-8909. Phone 404-562-7886; Fax 404-562-7881; TDD 404-562-7884, www.hhs.gov/ocr

There will be no retaliation for filing a complaint.

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.

Notes



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
COMMUNITY HEALTH

