

NEW EMPLOYEE
▶ HEALTH PLAN DECISION GUIDE

A SHARED SOLUTION





GEORGIA DEPARTMENT OF COMMUNITY HEALTH

PHONE NUMBERS AND CONTACTS FOR BENEFIT AND PROVIDER INFORMATION

PPO, PPO CHOICE OPTIONS (BASIC, PREMIER), INDEMNITY OPTIONS (BASIC, PREMIER)

- ▶ For rate information, contact your personnel/payroll representative
- ▶ For benefit coverage information, call Member Services at:
(800) 483-6983 (outside Atlanta),
or (404) 233-4479 (in Atlanta)

TDD line for the hearing impaired:
(800) 269-4719 (outside Atlanta),
(404) 842-8073 (in Atlanta)

You can get both National and Georgia
PPO provider information online at:
www.healthygeorgia.com

BEHAVIORAL HEALTH SERVICES

All Options except HMOs

Contact Magellan for provider and
referral information. 24 hours per day,
7 days per week. (800) 631-9943
www.magellanhealth.com

TDD line for hearing impaired:
(678) 319-3860 or (800) 201-8316

PRESCRIPTION DRUG PROGRAM INFORMATION

All Options except HMOs

Contact the Pharmacy Benefits Manager,
Express Scripts, at (877) 650-9342

TDD line for the hearing impaired:
(800) 842-5754

The Basic and Premier drug lists are
online at www.dch.state.ga.us

HMOs

BlueChoice Healthcare Plan

(800) 464-1367

Online provider information:
www.bcbsga.com

CIGNA HealthCare of Georgia

(800) 564-7642

Online provider information:
www.cigna.com

Kaiser Permanente

(404) 261-2590

(800) 611-1811

Online provider information:
www.kaiserpermanente.org

UnitedHealthcare of Georgia

(866) 527-9599

Online provider information:
www.provider.uhc.com/gdch

If you enroll for health insurance coverage under the State Health Benefit Plan (SHBP), you should receive a Summary Plan Description (SPD) from your Human Resources Department. This SPD reflects Plan benefits as of April 1, 2003. Each year, any Plan changes are printed in an *Updater*, which is your official notice of Plan changes. You may request a copy of the July 2003 and 2004 *Updaters* from your personnel office or you may print a copy from the DCH Web site, www.dch.state.ga.us. Please keep your Summary Plan Description (SPD) and *Updaters* 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.



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THE STATE HEALTH BENEFIT PLAN (SHBP)

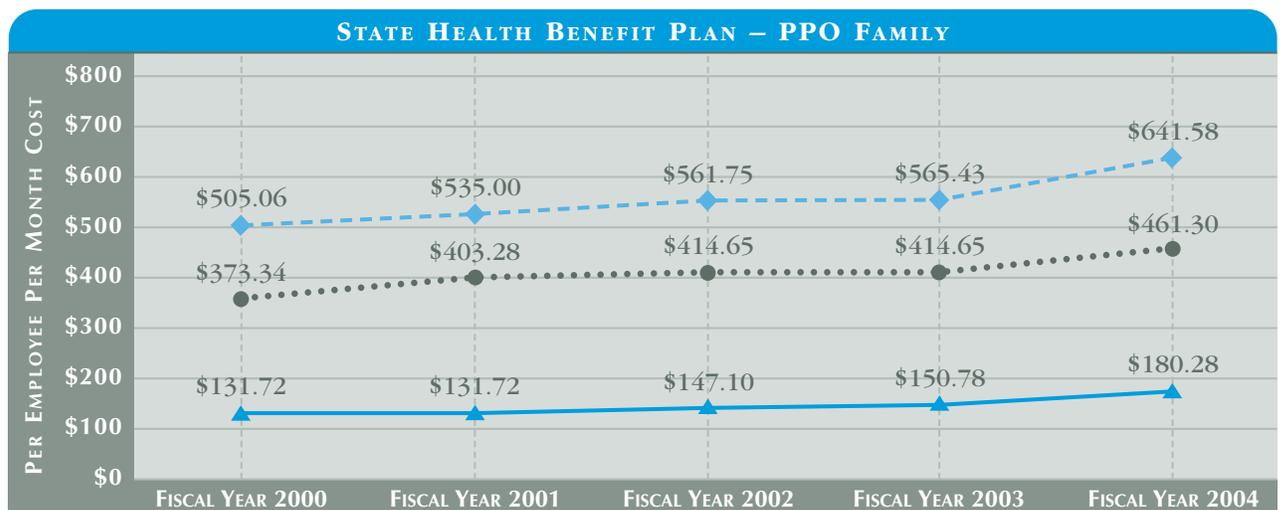
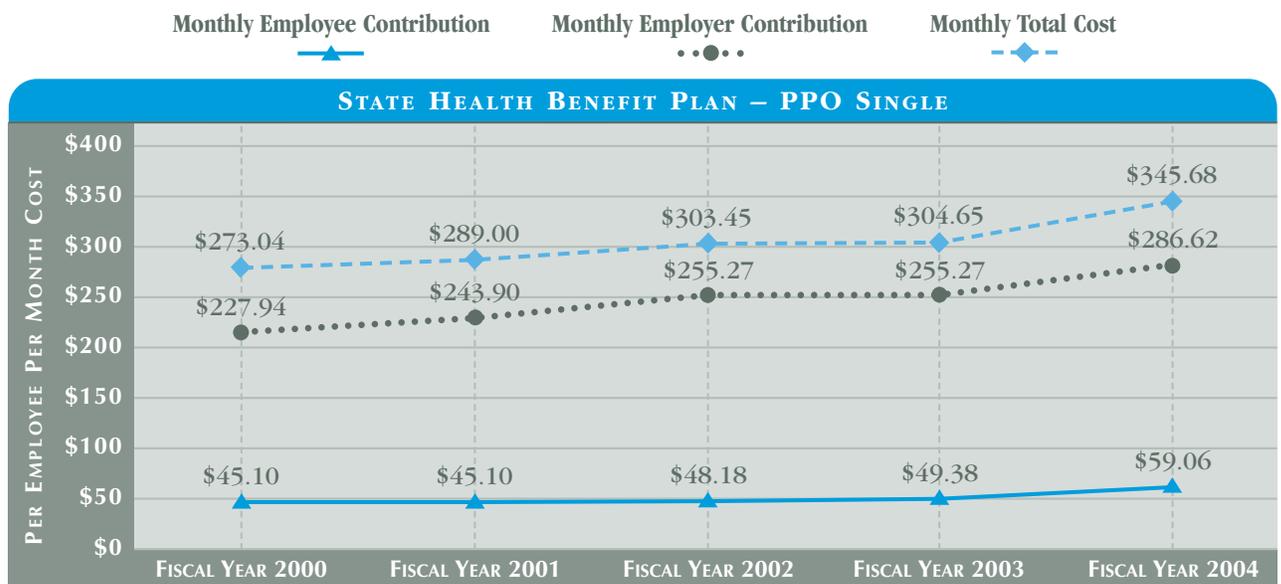
The Georgia Department of Community Health, which administers the State Health Benefit Plan (SHBP), continually seeks to offer high-quality, affordable health coverage. Keep in mind, however, that you are the manager of your healthcare needs, and in turn, must take the time to understand your Plan benefit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

You may wonder how much your healthcare benefits will cost this year. Monthly premiums continue to increase and benefits are modified. This is true for State Health Benefit Plan (SHBP) members as well as employees and retirees nationally. Why does this happen and how can we better manage healthcare costs? *Actually, you may be part of the solution.*

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 healthcare dollars, we have prepared a few points for you to consider.

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 95% of the premium goes directly to pay healthcare claims and 5% goes toward administering the Plan.

The graphs below provide you with an idea of how the cost of your healthcare is allocated between employees and employers.



So what can you do to help manage your healthcare costs and keep down the increase in premiums?

UNDERSTAND YOUR OPTIONS

Compare all your 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 front cover of the Decision Guide if you need more information.

CONSIDER ENROLLING IN A HEALTHCARE SPENDING ACCOUNT (HCSA)

A HCSA helps you save tax dollars, approximately 26-45%, depending on your tax situation. By electing to use a HCSA, you may set aside up to \$5,040 annually to cover health-related treatment for yourself and your dependents. Eligible expenses include deductibles, co-payments, 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're able to pay for these out-of-pocket costs with tax-free dollars! Contact your HR representative for more information.

BECOME A MORE PROACTIVE CONSUMER OF HEALTHCARE

Most people do not realize how much their treatments, medicines and tests cost. The illustration below is one example of the savings from choosing a generic drug instead of a brand-name drug.

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, not just the co-payment.
- ▶ Use generic medicines whenever possible.
- ▶ Make sure all procedures are precertified, if required.
- ▶ Make sure you get the results of any test or procedure.
- ▶ Talk to your provider. For example, ask your doctor if tests are necessary or if there are other forms of treatment.
- ▶ 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. As an informed consumer of healthcare, you can have an impact on what you have to pay for premiums and be part of the solution.

If after reading this Guide you want more information before making a coverage decision, you can request a Summary Plan Description (SPD) booklet and *Updaters* from your personnel/payroll office.

PRESCRIPTION	MEMBER CO-PAYMENT	TOTAL PRESCRIPTION COST	COST TO THE SHBP
BRAND NAME	\$25	\$90	\$65
GENERIC	\$10	\$42	\$32
SAVINGS	to you - \$15	-	to SHBP - \$33



GENERAL

INFORMATION

ELIGIBLE DEPENDENTS

A dependent is defined as:

- ▶ Your spouse, if you are legally married as defined by the state of Georgia;
- ▶ Your never-married dependent children who are:
 - 1 Natural or legally adopted children and under age 19;
 - 2 Stepchildren under age 19 who live with you at least 180 days per year;
 - 3 Other children under age 19 if they live with you permanently and legally depend on you for financial support;
 - 4 Your natural children, legally adopted children or stepchildren who were covered under the SHBP before age 19 and who are physically or mentally disabled and dependent on you for primary support (they may continue their existing Plan coverage past age 19); and
 - 5 Your children from categories 1, 2 or 3 above who are registered full-time students at fully accredited schools, are not employed full-time and are between the ages of 19 and 25.

DOCUMENTATION UPON REQUEST

In order to cover a spouse or dependent under the Plan, you must provide documentation *upon request* from the Plan. The Plan requires:

- ▶ A copy of your certified marriage license to cover spouses;
- ▶ A copy of a certified birth certificate to cover a natural child;
- ▶ A copy of a stepchild's certified birth certificate, showing your legal spouse as the natural parent of the child, and a notarized letter documenting that your stepchild lives in your home on a permanent basis in a parent-child relationship for at least 180 days per year;
- ▶ Adoption papers, guardian or court orders for other children who live with you permanently and legally depend on you for financial support. (The SHBP will recognize and honor a Qualified Medical Child Support Order (QMCSO) for eligible dependents. See your SPD for more information);
- ▶ Disability paperwork for disabled dependents 19 and over; this documentation must be received by the Plan before the child's 19th birthday; or
- ▶ A certification letter for full-time student dependents from the registrar's office of your child's school.

SHBP conducts random audits of Plan members' eligibility. Failure to provide the requested documentation within sixty days of the request, will result in the termination of the dependent's coverage retroactively to his or her coverage effective date. The recovery process to recover any and all payments made by the Plan on behalf of any ineligible dependents will begin 30 days after notification of cancellation.

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.
- ▶ As a result of a qualifying event. See *When Are Changes Allowed?* on page 6 of this Guide for more details.

If you elect to decline SHBP coverage, you must complete a Declination Form, available from your personnel/payroll office, and file it within 31 days of your hire date.

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

- ▶ Your coverage option—PPO Basic, PPO Premier, PPO Choice Basic, PPO Choice Premier, Indemnity Basic, Indemnity Premier, HMO Option or HMO Choice Option (if you live or work in an HMO service area); and
- ▶ Your coverage type—Single or Family coverage. For details on Single and Family coverage, see your SPD and *Updaters*.

Keep in mind that once you do enroll or decline, you cannot change your coverage voluntarily until the next Open Enrollment Period, unless you experience a qualifying event that would permit a corresponding change.

WHAT HAPPENS IF I HAVE OTHER INSURANCE?

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

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

It is important that you notify us if you have other group coverage to prevent incorrect processing of any claims. For further information about COB rules, refer to the SPD.

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 healthcare coverage if Plan coverage is lost due to a qualifying event. The length of time you may continue the coverage is based on the qualifying event. For further information, please refer to your SPD.

WHEN ARE CHANGES ALLOWED?

The benefit choices you make as a new hire will stay in effect for the duration of the 2004 - 2005 Plan year — July 1, 2004 - June 30, 2005, unless you experience certain changes in status as defined by federal law. Section 125 of the Internal Revenue Code, which governs the SHBP, does not permit canceling or otherwise changing your coverage during the Plan year unless you have a qualifying event.

Qualifying events include, but are not limited to:

- ▶ Marriage or divorce;
- ▶ Birth or adoption of a child or placement for adoption;
- ▶ Death of a spouse or child, if only dependent enrolled;
- ▶ Your spouse's or dependent's eligibility for or loss of eligibility for other group health coverage;
- ▶ A change in residence by you, your spouse or dependents that makes you or a covered dependent ineligible for coverage in your selected option; and
- ▶ A change in employment status that leads to a loss or gain of eligibility under the Plan.

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

For additional information about qualifying events, see your SPD available from your personnel office or online at www.dch.state.ga.us.

OVERVIEW OF HOW EACH HEALTH PLAN OPTION WORKS

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.

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 and *Updaters* online at www.dch.state.ga.us.

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. The Plan uses the following allowed amounts:

- 1 Network Rate—for in-network PPO services;
- 2 Out-of-Network Rate—for out-of-network PPO services; and
- 3 Indemnity Rate—for Indemnity Option services.

Balance Billing—A dollar amount charged by a 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 in the PPO or Indemnity Option. Depending on the option selected, the SHBP generally pays 90% to 60%, so your co-insurance is between 10% and 40%.

Co-payment—A set dollar amount that you pay at the time you receive services or items. For example, you pay a \$30 co-payment for an in-network PPO physician's office visit while you are at the physician's office. Co-payments do not apply to Plan year deductibles or out-of-pocket limits unless otherwise noted.

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 PPO Option or Indemnity Option pays a benefit. Depending on your coverage option, the deductible may not apply to some services. For example, the deductible does not apply to in-network physician office visits under the PPO Option. HMO Options do not have deductibles.

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 maximum dollar amount that each Plan member may receive in benefits from the SHBP during his or her lifetime.

Medical Certification Program (MCP)—A feature of the PPO and Indemnity Options that helps you and the Plan save money by preventing unnecessary care. To receive full benefits, you must comply with the MCP requirements outlined in the SPD and *Updaters*.

Out-of-Pocket Limit—A 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% of the allowed amounts for most covered services for the rest of the Plan year. Your out-of-pocket costs for premiums, co-payments and non-covered charges are **not** applied to the limit. The deductible is 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 PPO network, the Indemnity network or HMO network for the Plan option. Providers nominated and accepted under a Choice Option also are considered participating providers for the person making the nomination. Participating providers may not balance bill Plan members for covered services.

PRE-EXISTING CONDITIONS AND COVERAGE LIMITS

A Pre-existing Condition (PEC) is any sickness, injury or other condition (except as noted below) for which medical advice, diagnosis, care or treatment, including prescription medication, was recommended or received within six months immediately preceding a member's coverage effective date under the Plan.

New SHBP members who enroll in the PPO or Indemnity Option and have a PEC have a 12-month coverage limitation period for their PECs. Coverage for each PEC is limited to \$1,000 during the first 12 months of Plan coverage.

For new employees, the 12-month coverage limitation period begins the first day of the month in which the new employee was hired.

The PEC limitation period does not apply to coverage for pregnancy, for a newborn, or for a newly adopted child or a child placed for adoption under the age of 18, if the child becomes covered within 31 days of birth or adoption.

Enrollees are treated as new members, subject to the PEC limitation period, if they are enrolling in the PPO or Indemnity Option after a coverage break of four or more months.

CREDITABLE COVERAGE

SHBP members and dependents can reduce or eliminate the 12-month PEC limitation period by documenting "creditable coverage." Creditable coverage generally includes the health coverage you or a family member had immediately before joining the SHBP. Coverage under most group health plans, individual health policies and some governmental health programs qualifies as creditable coverage.

To reduce or eliminate 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.



OVERVIEW OF

PLAN OPTIONS

The State Health Benefit Plan has contracted with healthcare organizations that have been carefully reviewed and selected to provide the highest level of provider accessibility and quality of care. When selecting your health plan option, it is extremely critical that you fully understand how the provider network functions for the various health plan options.

INDEMNITY OPTIONS – BASIC AND PREMIER

The Indemnity Options are traditional fee-for-service plans that generally provide the same benefit coverage level no matter which qualified medical provider you use. These Plans reimburse up to the Plan's allowed amounts for covered services. The Indemnity Options also use contracted healthcare providers who have agreed to discounted rates without balance billing for charges over the allowed amount. As long as you use a participating provider, you may not be balance billed for covered services. However, not all Georgia providers participate in these special arrangements and **there are no participating Indemnity Network providers outside of Georgia**. In most instances, non-participating providers' billed charges are considerably higher than the Plan's allowed amounts. Hospital stays (even for emergencies) outside of Georgia can result in significant balance billing amounts. In some cases, this can be well in excess of \$10,000.

There are two pharmacy options under the Indemnity Plan Options. These options are the Indemnity Basic and Indemnity Premier. The medical benefits are the same under the Basic and Premier options. For additional information refer to page 26 of this Guide.

Note: Some contract groups that participate in the SHBP are not eligible to participate in the Indemnity Option.

Points to Consider

- ▶ You may access any provider.
- ▶ You may pay most healthcare bills up to the deductible amount before the Plan starts paying benefits.
- ▶ You continue to pay co-insurance for covered services after meeting the deductible (up to the out-of-pocket maximum).
- ▶ When using a non-participating provider, including all out-of-state providers, you are subject to balance billing for charges over the allowed amounts. These amounts do not apply to the out-of-pocket maximum.
- ▶ Compare the Basic and Premier Pharmacy Options.
- ▶ You must call the Medical Certification Program (MCP) to precertify inpatient stays at non-participating hospitals, and members must precertify certain outpatient tests and procedures. Financial penalties apply if precertification rules are not followed.

NOTE: The State Health Benefit Plan does not have the legal authority to intervene when non-participating providers balance bill; therefore, the State Health Benefit Plan cannot reduce or eliminate amounts balance billed. In addition, the Health Plan cannot make additional payments above the allowed amounts when you are balance billed by non-participating providers.

PPO AND PPO CHOICE OPTIONS – BASIC AND PREMIER

The PPO Options offer you a network of over 14,000 Georgia participating physicians and 166 Georgia hospitals managed by 1st Medical Network in the Georgia service area.* You also have the added benefit of access to a national network of participating providers and hospitals across the United States, which is managed by the Beech Street Corporation. The PPO Options offer you the choice and flexibility of using in-network or out-of-network providers. In order to receive the highest level of benefit coverage and avoid filing claims and balance billing, you will need to use an in-network provider. If you choose to use an out-of-network provider, the reimbursement will be at a lower level of benefit coverage. Note: The Transplant and Behavioral Health Services (BHS) networks are separate from the 1st Medical Network and the Beech Street Network.

To view the list of PPO providers online, visit www.healthygeorgia.com. If you do not have Internet access, call Member Services for provider information.

It is ultimately your responsibility to verify if a provider participates in the PPO network prior to receiving services. Providers may enter or leave the network at any time.

There are two pharmacy options under the PPO and PPO Choice Options — PPO Basic and PPO Premier. The medical benefits are the same under the PPO and PPO Choice Options. Please refer to page 26 for additional information.

Points to Consider

- ▶ You do not need to select a primary care physician (PCP) or obtain referrals to see specialists.
- ▶ No balance billing when using participating PPO providers.
- ▶ You pay a minimal co-payment for in-network PPO physician visits. Other covered services are subject to deductibles and co-insurance.
- ▶ You may access any licensed out-of-network physician, specialist or hospital at any time. However, you will generally pay more for out-of-network services and charges are subject to balance billing.
- ▶ You must call the Medical Certification Program (MCP) to precertify inpatient stays and specified outpatient procedures when you are using out-of-network providers or Beech Street providers (National PPO network).
- ▶ Some physicians affiliated with our PPO networks may not accept new patients at certain times during the year or may drop out during the year. Please check with the physician of your choice before you enroll in one of the PPO Options.
- ▶ Compare the pharmacy programs.
- ▶ In-network hospitals may contract with out-of-network physicians or labs. You may be subject to balance billing by these providers.
- ▶ You have access to a national network of Beech Street providers. Your level of benefit coverage is generally different and you are subject to separate deductibles and out-of-pocket maximums.
- ▶ Physicians or hospitals leaving the network are not considered a qualifying event and do not allow you to change coverage.

The Georgia service area includes the state of Georgia and the border communities of the Chattanooga, Tennessee area, including Bradley County; and Phenix City, Alabama. The zip code area in which you **receive a service is used to determine whether or not you are in the Georgia service area. See page 30 for further information.*

ADDITIONAL INFORMATION ABOUT PPO CHOICE – BASIC AND PREMIER

Benefits under the PPO Choice Options are the same in the PPO Basic and PPO Premier Options. However, PPO Choice Option premiums are higher. In return for a higher premium, you can request that an out-of-network Georgia provider be reimbursed as an in-network provider. This request is known as a “nomination.” If the out-of-network provider accepts your nomination, agrees to the PPO fees, and is approved by the PPO, you will receive in-network benefits for that provider. The in-network relationship between you and the provider remains in effect until you or the provider terminates the agreement. You may nominate as many eligible providers as you wish at any time during the Plan year.

Points to Consider

- ▶ The PPO must approve your provider nomination **before** you receive services.
- ▶ If your provider does not accept your nomination, does not accept the network fees, or is not approved by the PPO Network Administrator, then services from that provider are covered at the lower, out-of-network benefit level. **SHBP rules do not allow a member to change options when a nominated provider or the PPO rejects a nomination.**
- ▶ Only providers located and licensed in Georgia can be nominated, even if you live out of state. After the PPO receives your nomination, the PPO has three business days to either reject or approve the nomination.

For further details regarding the nomination process and to obtain the necessary paperwork, please contact Member Services.

Note: The Behavioral Health Services (BHS) and transplant provider networks are separate from the PPO provider network in all PPO and PPO Choice Options. To nominate a BHS provider, contact the BHS Program at (800) 631-9943. For nominations of transplant providers, call (800) 828-6518 (outside Atlanta).

HMO OPTIONS

HMO Options are available only to SHBP-eligible employees who live or work in an approved HMO service area in Georgia. ***(See footnote.)** Please review the approved HMO service area list on pages 31–34 of this Guide to determine if you are eligible for an HMO. If your residence circumstances change during the Plan year and you no longer live or work in an approved HMO service area, you will be required to change to another Plan option.

HMOs provide prepaid benefits for most health-care needs, with no bills or claim forms. You are responsible for selecting a primary care physician (PCP) from a list of participating providers. **** (See footnote.)** You must receive care from your PCP or from a physician or facility referred by your PCP for your expenses to be covered, except in cases of emergency and in other limited cases. If you receive care from a physician other than your PCP, or without your PCP referral, there is no coverage even if the physician or facility is in the HMO network.

Points to Consider

- ▶ You must access physicians, specialists and hospitals offered through the HMO's network to receive benefits, except for emergencies as defined by the HMO.
- ▶ You choose a PCP to serve as your first point of contact for most healthcare services. **** (See footnote.)** Your covered family members must also select a PCP. The PCP is responsible for coordinating your healthcare services (specialists, ancillary providers, hospitals).
- ▶ Providers may drop out of the network at any time during the year and this is not a qualifying event to change coverage.
- ▶ See the Pharmacy Benefit Options on page 26 to compare the pharmacy programs.
- ▶ You pay only a minimal co-payment for HMO in-network physician visits, prescription drugs and some other covered services.
- ▶ You pay the full cost for non-referred services and for services received outside the HMO's participating network, except for emergencies as defined by the HMO.
- ▶ You have coordinated care through a network of HMO participating providers.
- ▶ In most cases, HMOs do not have a deductible to meet, so your out-of-pocket cost may be lower.
- ▶ There are no pre-existing condition limitations.
- ▶ You may be required to follow the HMO's standardized treatment plan for your condition. For example, you may be required to receive treatment from your primary care physician for a specified period before being referred to a specialist.
- ▶ All services received outside the State of Georgia must be coordinated through the HMO.

(*) Some contract groups that participate in the SHBP are not eligible to participate in the HMO Options.

() Note: UnitedHealthcare HMO does not require you to select a PCP or obtain referrals to see specialists.**

HMO CHOICE OPTIONS

If you are eligible for an HMO Option, you also are eligible for that HMO's Choice Option.

HMO Choice Option benefits are the same as the respective regular HMO Option benefits. However, the Choice Option premiums are higher. In return for a higher premium, the HMO Choice Option gives members the opportunity to request an out-of-network Georgia provider to be treated as an in-network provider. This request is known as a "nomination." You may nominate providers if they are located and licensed in Georgia and offer services covered by the HMO. In addition, you may nominate as many eligible providers as you wish at any time during the Plan year.

Points to Consider

- ▶ The HMO must approve your out-of-network provider **before** you receive medical services.
- ▶ If the out-of-network provider accepts your nomination, accepts the HMO's fees and is approved by the HMO, you may receive in-network benefits from that provider.
- ▶ If your provider does not accept your nomination, does not accept the HMO's fees, or is not approved by the HMO, services from that provider are not covered.
- ▶ Referral rules apply when the nominated doctor is a specialist for the BlueChoice, CIGNA and Kaiser HMOs.
- ▶ **SHBP rules do not permit a member to change options when a nominated provider or HMO rejects a nomination.**

Please contact the Member Services Department of the respective HMO directly to find out more about the required procedures and paperwork necessary to nominate a provider. Telephone numbers are listed on the inside front cover.

YOU ARE PART OF THE SOLUTION!

UNDERSTANDING YOUR HEALTH PLAN OPTIONS

This section compares specific benefits within the PPO, Indemnity and HMO Options. For more specific information on covered services, call the Member Services numbers listed on the inside front cover.





BENEFITS COMPARISON: PPO, INDEMNITY AND HMO OPTIONS

SCHEDULE OF BENEFITS FOR YOU AND YOUR DEPENDENTS — JULY 1, 2004

COVERED SERVICES	PPO AND PPO CHOICE OPTIONS — BASIC AND PREMIER		
	PPO OPTION In-Network/Georgia	PPO OPTION In-Network/Out-of-State	PPO OPTION Out-of-Network
	<i>The Plan Pays:</i>	<i>The Plan Pays:</i>	<i>The Plan Pays:</i>
Maximum Lifetime Benefit (combined for all SHBP Options)	\$2 million		
Pre-Existing Conditions (1st year in Plan only, subject to HIPAA)	\$1,000		
Lifetime Benefit Limit for Treatment of: (combined for PPO Option and Indemnity) <ul style="list-style-type: none"> ▶ Temporomandibular joint dysfunction (TMJ) ▶ Substance abuse ▶ Organ and tissue transplants ▶ Home hyperalimentation 	\$1,100 3 episodes \$500,000 \$500,000		
Deductibles/Co-Payments: <ul style="list-style-type: none"> ▶ Deductible—individual ▶ Deductible—family maximum 	\$400 \$1,200	In-Network/Out-of-State & Out-of-Network amounts combined \$500 \$1,500	
<ul style="list-style-type: none"> ▶ Hospital deductible/admission—excluding BHS and transplants ▶ Hospital deductible/admission—BHS and transplants ▶ Hospital co-payment 	\$250 \$100 None	\$250 \$100 None	\$250 \$100 None
Annual Out-of-Pocket Limits: <ul style="list-style-type: none"> ▶ Individual (you or one of your dependents) ▶ Family (you and your dependents) 	\$1,000 \$2,000	In-Network/Out-of-State & Out-of-Network amounts combined \$2,000 \$4,000	
<ul style="list-style-type: none"> ▶ BHS program (per patient); BHS authorized care only 	\$2,500		
PHYSICIANS' SERVICES			
Primary Care Physician and/or Referral Required	No	No	No
Primary Care Physician or Specialist Office or Clinic Visits: <ul style="list-style-type: none"> ▶ Treatment of illness or injury 	100% NR* after a per visit co-payment of \$30; not subject to deductible	100% NR* after a per visit co-payment of \$30; not subject to deductible	60% of OONR*; subject to deductible

* See legend on page 24 for definitions of NR, OONR and IR.

INDEMNITY OPTIONS	
BASIC AND PREMIER	
<i>The Plan Pays:</i>	
\$2 million	
\$1,000	
\$1,100 3 episodes \$500,000 \$500,000	
\$400 \$1,200	
\$400	
\$100	
None	
\$2,000 \$4,000	
\$2,500	
No	
90% of IR*; subject to deductible	

HMO OPTIONS			
BLUECHOICE	CIGNA	KAISER PERMANENTE	UNITEDHEALTHCARE
<i>The Plan Pays:</i>			
\$2 million	\$2 million	No lifetime benefit maximums	\$2 million
None	None	None	None
No separate lifetime benefit limit			
Not applicable	Not applicable	Not applicable	Not applicable
Not applicable	Not applicable	Not applicable	Not applicable
Not applicable	Not applicable	Not applicable	Not applicable
\$200	\$200	\$200	\$200
Not applicable	Not applicable	Not applicable	Not applicable
Not applicable	Not applicable	Not applicable	Not applicable
Yes	Yes	Yes	No
100% after a per visit co-payment of \$15 for primary care and \$20 for specialty care	100% after a per visit co-payment of \$15 for primary care and \$20 for specialty care	100% after a per visit co-payment of \$15 for primary care and \$20 for specialty care	100% after a per visit co-payment of \$15 for primary care and \$20 for specialty care

PPO AND PPO CHOICE OPTIONS — BASIC AND PREMIER

COVERED SERVICES	PPO OPTION In-Network/Georgia	PPO OPTION In-Network/Out-of-State	PPO OPTION Out-of-Network
	<i>The Plan Pays:</i>	<i>The Plan Pays:</i>	<i>The Plan Pays:</i>
Primary Care Physician or Specialist Office or Clinic Visits for the Following: <ul style="list-style-type: none"> ▶ Wellness care/preventive healthcare ▶ Well-newborn exam ▶ Well-child exams and immunizations ▶ Annual physicals ▶ Annual gynecological exams 	100% of NR after \$30 co-payment per office visit. 100% of NR with no co-payment for associated tests and immunizations. Maximum of \$500 payable per person per Plan year for all preventive services. Maximum combined with In-Network/Out-of-State benefit.	100% of NR after \$30 co-payment per office visit. 100% of NR with no co-payment for associated tests and immunizations. Maximum of \$500 payable per person per Plan year for all preventive services. Maximum combined with In-Network/Georgia benefit.	Not covered. Charges do not apply to deductible or annual out-of-pocket limits.
Notes: Lab and test charges include such services as mammograms, prostate screenings/PSAs, and pap tests. Covered according to preventive care age schedules. Covered care schedules are online at www.healthygeorgia.com or call Member Services at (800) 483-6983 (outside Atlanta) or (404) 233-4479 (inside Atlanta).			
Maternity Care (prenatal, delivery and postpartum)	90% of NR; not subject to deductible after initial \$30 co-payment	80% of NR; not subject to deductible after initial \$30 co-payment	60% of OONR; subject to deductible and to balance billing
Physician Services Furnished in a Hospital <ul style="list-style-type: none"> ▶ Surgery in general, including charges by surgeon, anesthesiologist, pathologist and radiologist 	90% of NR; subject to deductible	80% of NR; subject to deductible	60% of OONR; subject to deductible
<ul style="list-style-type: none"> ▶ Inpatient well-newborn exams 	100% of NR; not subject to deductible	100% of NR; not subject to deductible	Not covered
Physician Services for Emergency Care	90% of NR; subject to deductible	90% of NR; subject to In-Network/Georgia deductible	90% of NR; subject to In-Network/Georgia deductible and to balance billing
Outpatient Surgery - <ul style="list-style-type: none"> ▶ When billed as office visit 	90% of NR; subject to deductible	80% of NR; subject to deductible	60% of OONR; subject to deductible
<ul style="list-style-type: none"> ▶ When billed as outpatient surgery at a facility 	90% of NR; subject to deductible	80% of NR; subject to deductible	60% of OONR; subject to deductible
HOSPITAL SERVICES			
Inpatient Services <ul style="list-style-type: none"> ▶ Inpatient care, delivery and inpatient short-term acute rehabilitation services 	90% of NR; subject to a per admission deductible of \$250	80% of NR; subject to a per admission deductible of \$250	60% of OONR; subject to a per admission deductible of \$250
<ul style="list-style-type: none"> ▶ Outpatient services <ul style="list-style-type: none"> ▶ Non-emergency use of the emergency room ▶ Other 	90% of NR; subject to deductible; subject to \$100/visit co-payment	80% of NR; subject to deductible; subject to \$100/visit co-payment	60% of OONR; subject to deductible; subject to \$100/visit co-payment
<ul style="list-style-type: none"> ▶ Well-newborn care 	100% of NR; not subject to deductible	100% of NR; not subject to deductible	Not covered

INDEMNITY OPTIONS
BASIC AND PREMIER
<i>The Plan Pays:</i>
90% of IR per office visit after deductible. 100% of IR with no deductible for associated lab and test charges, up to a maximum of \$200 per person per Plan year; additional \$125 benefit for screening mammogram.
Note: PPO notes to the left also apply here.
90% of IR; subject to deductible
90% of IR; subject to deductible
Not covered
90% of IR; subject to deductible and to balance billing from non-participating providers
90% of IR; subject to deductible
90% of IR; subject to deductible
90% of IR; subject to a per admission deductible of \$400
90% of IR; subject to deductible. If services are in conjunction with non-emergency use of the emergency room, benefit also subject to \$100/visit co-payment
90% of IR; subject to per admission deductible of \$100

HMO OPTIONS			
BLUECHOICE	CIGNA	KAISER PERMANENTE	UNITEDHEALTHCARE
<i>The Plan Pays:</i>	<i>The Plan Pays:</i>	<i>The Plan Pays:</i>	<i>The Plan Pays:</i>
100% after a per visit co-payment of \$15 for primary care and \$20 for specialty care. No co-payment for immunizations and mammograms.	100% after a per visit co-payment of \$15 for primary care and \$20 for specialty care. No co-payment for immunizations and mammograms.	100% after a per visit co-payment of \$15 for primary care and \$20 for specialty care. No co-payment for immunizations and mammograms.	100% after a per visit co-payment of \$15 for primary care and \$20 for specialty care. No co-payment for immunizations and mammograms.
100% after initial \$20 co-payment			
100%	100%	100%	100%
100%	100%	100%	100%
100% after applicable co-payment			
100% after \$20 co-payment if billed as office visit	100% after \$20 co-payment if billed as office visit	100% after \$20 co-payment if billed as office visit	100% after \$20 co-payment if billed as office visit
\$100 co-payment for outpatient surgery			
100% after \$200 per confinement co-payment			
PCP prior authorization required for coverage	PCP prior authorization required for coverage	PCP prior authorization required for coverage	Requires prior authorization from HMO
100%	100%	100%	100%

PPO AND PPO CHOICE OPTIONS — BASIC AND PREMIER

	PPO OPTION In-Network/Georgia	PPO OPTION In-Network/Out-of-State	PPO OPTION Out-of-Network
COVERED SERVICES	<i>The Plan Pays:</i>	<i>The Plan Pays:</i>	<i>The Plan Pays:</i>
Outpatient Surgery - Hospital/Facility	90% of NR; subject to deductible	80% of NR; subject to deductible	60% of OONR; subject to deductible
Emergency Care ▶ Treatment of an emergency medical condition or injury	90% NR after a per visit co-payment of \$100; co-insurance and hospital deductible apply, if admitted	90% NR after a per visit co-payment of \$100; co-insurance and hospital deductible apply, if admitted	90% OONR after a per visit co-payment of \$100; co-insurance and hospital deductible apply, if admitted. Subject to balance billing.
Note: \$100 co-payments are reduced to \$80 if referred by NurseCall 24 before receiving emergency room services. The ER co-payment is waived, if admitted within 24 hours.			
OUTPATIENT TESTING, LAB, ETC.			
Laboratory; X-Rays; Diagnostic Tests; Injections, including Medications Covered Under Medical Benefits - for the Treatment of an Illness or Injury	90% of NR; subject to deductible	80% of NR; subject to deductible	60% of OONR; subject to deductible
Allergy Shots and Serum	100% of NR; not subject to the deductible. If physician is seen, visit is treated as an office visit subject to the per visit copayment of \$30	100% of NR; not subject to the deductible. If physician is seen, visit is treated as an office visit subject to the per visit copayment of \$30	60% of OONR; subject to deductible
Allergy Testing	90% of NR; subject to deductible	80% of NR; subject to deductible	60% of OONR; subject to deductible
BEHAVIORAL HEALTH			
Mental Health and Substance Abuse Inpatient Facility	90% of NR; subject to deductible and separate hospital deductible, if admitted when authorized by BHS	90% of NR; subject to deductible and separate hospital deductible, if admitted when authorized by BHS	60% of NR; subject to deductible and separate hospital deductible, if admitted when authorized by BHS
Note: 1. All services require prior authorization. 2. Inpatient facility charges (limited to 60 combined mental health and substance abuse days per person per Plan year). 3. Substance Abuse coverage limited to three episodes per lifetime.			
Partial Day Hospitalization and Intensive Outpatient	90% of NR; subject to deductible and separate hospital deductible, if admitted when authorized by BHS	90% of NR; subject to deductible and separate hospital deductible, if admitted when authorized by BHS	No benefit
Note: 1. Maximum benefit of 30 combined PHP/IOP visits/days per person per Plan year. 2. Benefit coverage is only available when using an in-network Magellan provider for partial/day hospitalization and intensive outpatient charges.			

INDEMNITY OPTIONS
BASIC AND PREMIER
<i>The Plan Pays:</i>
90% of IR; subject to deductible
90% IR after a per visit co-payment of \$100; co-insurance and hospital deductible, if admitted, apply. Subject to balance billing from non-participating providers.

Note: PPO note to the left also applies here.
90% of IR; subject to deductible
90% of IR; subject to deductible
90% of IR; subject to deductible
90% of IR; subject to deductible if admitted when authorized by BHS

Note: PPO notes to the left also apply here.
90% of IR; subject to deductible and separate hospital deductible, if admitted

Note: PPO notes to the left also apply here.

HMO OPTIONS			
BLUECHOICE	CIGNA	KAISER PERMANENTE	UNITEDHEALTHCARE
<i>The Plan Pays:</i>	<i>The Plan Pays:</i>	<i>The Plan Pays:</i>	<i>The Plan Pays:</i>
100% after \$100 per confinement co-payment	100% after \$100 per confinement co-payment	100% after \$100 per confinement co-payment	100% after \$100 per confinement co-payment
100% after a per visit co-payment of \$50 (co-payment waived if admitted)	100% after a per visit co-payment of \$50 (co-payment waived if admitted)	100% after a per visit co-payment of \$50 (co-payment waived if admitted)	100% after a per visit co-payment of \$50 (co-payment waived if admitted)
100%	100%	100%	100%
100% for shots and serum after a \$20 co-payment per visit	100% for shots and serum after a \$20 co-payment per visit	\$5 for shots and \$50 for a six-month supply of serum	100% for shots and serum after a \$20 co-payment per visit
100% after a \$20 per visit co-payment	100% after a \$20 per visit co-payment	100% after a \$20 per visit co-payment	100% after a \$20 per visit co-payment
100% after \$50 co-payment per confinement; limited to 30 days per Plan year	100% after \$50 co-payment per confinement; limited to 30 days per Plan year	100% after \$50 co-payment per confinement; unlimited days for mental health; 30-day limit for substance abuse	100% after \$50 co-payment per confinement; limited to 30 days per Plan year
-----	-----	-----	-----
Outpatient Care: 100% after \$20 per visit co-payment; limited to 25 visits per Plan year	Outpatient Care: 100% after \$20 per visit co-payment; limited to 25 visits per Plan year	Outpatient Care: 100% after \$20 per visit co-payment; unlimited days for mental health; limited to 25 visits for substance abuse per Plan year	Outpatient Care: 100% after \$20 per visit co-payment; limited to 25 visits per Plan year
\$50 co-payment per confinement; contact HMO for specifics	\$50 co-payment per confinement; contact HMO for specifics	\$50 co-payment per confinement; contact HMO for specifics	\$50 co-payment per confinement; contact HMO for specifics

PPO AND PPO CHOICE OPTIONS — BASIC AND PREMIER

COVERED SERVICES	PPO OPTION In-Network/Georgia	PPO OPTION In-Network/Out-of-State	PPO OPTION Out-of-Network
	<i>The Plan Pays:</i>	<i>The Plan Pays:</i>	<i>The Plan Pays:</i>
23 Hour Observation Room (requires prior authorization to receive coverage.)	90% of NR; subject to \$100 deductible	90% of NR; subject to \$100 deductible	No benefit
Professional Charges Inpatient (combined total for substance abuse and mental health)	80% of NR; subject to deductible. Maximum 1 visit per authorized day when authorized by BHS.	80% of NR; subject to deductible. Maximum 1 visit per authorized day when authorized by BHS.	50% of NR; subject to deductible and balance billing. Maximum of 25 professional visits per person per Plan year.
Outpatient (Precertification required to receive coverage.)	80% of NR; subject to deductible when authorized by BHS, limited to 50 visits per Plan year.	80% of NR; subject to deductible when authorized by BHS, limited to 50 visits per Plan year.	50% of NR; subject to deductible (without authorization) and balance billing. Maximum 25 combined mental health, substance abuse and brief therapy visits per person per Plan year. Limited to services rendered by a Psychiatrist (M.D.) or a Psychologist (Ph.D.)
	Note: In-network maximum coverage of 50-combined mental health, substance abuse, and brief therapy visits per person per Plan year. Limit includes 25 out-of-network counseling sessions and 3 brief visits.		
Brief-Visit Therapy (limit - 3 visits per Plan year; requires BHS prior authorization.)	100%; not subject to deductible	90%; not subject to deductible	No benefit
	Note: Visits are included in the 50-visit limit of outpatient care.		
DENTAL			
Dental and Oral Care Coverage for most procedures for the prompt repair of sound natural teeth or tissue for the correction of damage caused by traumatic injury	90% of NR; subject to deductible and, if admitted, to hospital deductible. Network providers may not be available for all covered services; charges are paid at 90% NR, subject to balance billing	80% of NR; subject to deductible and, if admitted, to hospital deductible. Network providers may not be available for all covered services; charges are paid at 80% NR, subject to balance billing	60% of OONR; subject to deductible and, if admitted, to hospital deductible
Coverage of specific osseous surgeries for the treatment of periodontal disease	Not covered	Not covered	Not covered
Temporomandibular joint syndrome (TMJ) Note: Coverage for diagnostic testing and non-surgical treatment of TMJ, up to \$1,100 per person lifetime maximum benefit. This does not apply to the HMOs.	90% of NR; subject to deductible	80% of NR; subject to deductible	60% of OONR; subject to deductible

INDEMNITY OPTIONS
BASIC AND PREMIER
<i>The Plan Pays:</i>
90% of IR; subject to \$100 deductible
80% of IR; subject to deductible and balance billing. PPO benefits apply when authorized by BHS.
80% of IR; subject to deductible when authorized by BHS, limited to 50 visits per Plan year.

Note: PPO notes to the left also apply here.
100%; not subject to deductible

Note: PPO note to the left also applies here.
90% of IR; subject to deductible and, if admitted, to hospital deductible.

Not covered
90% of IR; subject to deductible

HMO OPTIONS			
BLUECHOICE	CIGNA	KAISER PERMANENTE	UNITEDHEALTHCARE
<i>The Plan Pays:</i>	<i>The Plan Pays:</i>	<i>The Plan Pays:</i>	<i>The Plan Pays:</i>
100% after \$50 co-payment	100% after \$50 co-payment	100% after \$50 co-payment	100% after \$50 co-payment
100%	100%	100%	100%
100% after \$20 co-payment	100% after \$20 co-payment	100% after \$20 co-payment	100% after \$20 co-payment
Contact HMO for specifics	Contact HMO for specifics	Contact HMO for specifics	Contact HMO for specifics
100% after applicable oral surgery co-payment and dental services for accidental injury to sound teeth	100% after applicable oral surgery co-payment and dental services for accidental injury to sound teeth	Services/appliances for accidental injury to sound and natural teeth: 50% coverage on first \$1,000, 100% thereafter	100% after applicable oral surgery co-payment and dental services for accidental injury to sound teeth
-----	-----	-----	-----
Not covered	Not covered	Not covered	Not covered
100% after applicable co-payment for related surgery and diagnostic services. Excludes appliances and orthodontic treatment.	100% after applicable co-payment for related surgery and diagnostic services. Excludes appliances and orthodontic treatment.	50% for non-surgical treatment; 100% after applicable co-payment for related surgery and diagnostic services. Excludes appliances and orthodontic treatment.	100% after applicable co-payment for related surgery and diagnostic services. Excludes appliances and orthodontic treatment.

PPO AND PPO CHOICE OPTIONS — BASIC AND PREMIER

	PPO OPTION In-Network/Georgia	PPO OPTION In-Network/Out-of-State	PPO OPTION Out-of-Network
COVERED SERVICES	<i>The Plan Pays:</i>	<i>The Plan Pays:</i>	<i>The Plan Pays:</i>
VISION			
	Note: PPO Options include a discount program for vision screenings and eyewear. Contact BlueChoice Vision Program at (800) 377-6436 or visit www.bcbsga.com for more information. Vision program availability is subject to change during the Plan year.		
OTHER COVERAGE			
Ambulance Services for Emergency Care Note: "Land or air ambulance" to nearest facility to treat the condition. Note: Limited to transportation for emergencies and benefits subject to balance billing for non-participating providers of ambulance services.	90% of NR; subject to deductible	90% of NR; subject to In-Network/Georgia deductible	90% of OONR; subject to In-Network/Georgia deductible
Urgent Care Services in an Approved Urgent Care Center	90% of NR after a per visit co-payment of \$45; subject to deductible	90% of NR after a per visit co-payment of \$45; subject to deductible	Not applicable
Home Healthcare Services Approved in Advance by the MCP ----- Notes: Home nursing care not reviewed by the MCP. Covers two hours of medically necessary skilled home care per day by RN or LPN if ordered by a physician; \$7,500 per Plan year limit is a combined total in PPO Options. Member's share of cost is not applied to Plan year out-of-pocket limits.	90% of NR; subject to deductible	80% of NR; subject to deductible	60% of OONR; subject to deductible
Skilled Nursing Facility Services	Not covered	Not covered	Not covered
Hospice Care Note: Indemnity - MCP may approve additional benefits in lieu of Acute Care hospitalization.	100% of NR; subject to deductible	100% of NR; subject to deductible	60% of OONR; subject to deductible
Durable Medical Equipment (DME) – Rental or Purchase	90% of NR; subject to deductible	80% of NR; subject to deductible	60% of OONR; subject to deductible
Outpatient Acute Short-Term Rehabilitation Services ----- Note: Coverage for up to 40 visits per Plan year when conditions are met for physical, speech, occupational therapies and for cardiac rehabilitation.	90% of NR; subject to deductible and \$20 per visit co-payment	80% of NR; subject to deductible and \$20 per visit co-payment	60% of OONR; subject to deductible

INDEMNITY OPTIONS
BASIC AND PREMIER
<i>The Plan Pays:</i>
Note: PPO note to the left also applies here.
90% of IR; subject to deductible
90% of IR; subject to deductible
90% of IR; subject to deductible
----- Note: PPO notes to the left also apply here.
Not covered
100% of IR, up to Medicare's approved lifetime maximum; subject to deductible
90% of IR; subject to deductible
90% of IR; subject to deductible
----- Note: PPO note to the left also applies here.

HMO OPTIONS			
BLUECHOICE	CIGNA	KAISER PERMANENTE	UNITEDHEALTHCARE
<i>The Plan Pays:</i>	<i>The Plan Pays:</i>	<i>The Plan Pays:</i>	<i>The Plan Pays:</i>
Each HMO Option may offer vision care discounts or benefits. Contact the HMO directly for more information.			
100%	100%	100% after a \$50 per trip co-payment when medically necessary	100%
100% after \$25 co-payment, referral required	100% after \$25 co-payment	100% after \$30 co-payment	100% after \$25 co-payment
100%; up to 120 visits per Plan year	100%; up to 120 visits per Plan year	100%; up to 120 visits per Plan year	100%; up to 120 visits per Plan year
100%; prior approval required, up to 45 days per Plan year	100%; prior approval required, up to 45 days per Plan year	100%; prior approval required, up to 45 days per Plan year	100%; prior approval required, up to 120 days per Plan year
100%; prior approval required	100%; prior approval required	100%; prior approval required	100%; prior approval required
100% when medically necessary	100% when medically necessary	100% when medically necessary	100% when medically necessary
100% after \$20 per visit co-payment; up to 40 visits per Plan year	100% after \$20 per visit co-payment; up to 40 visits per Plan year	100% after \$20 per visit co-payment; up to 40 visits per Plan year or up to two consecutive months per condition, whichever is more	100% after \$20 per visit co-payment; up to 40 visits per Plan year

PPO AND PPO CHOICE OPTIONS — BASIC AND PREMIER

COVERED SERVICES	PPO OPTION In-Network/Georgia	PPO OPTION In-Network/Out-of-State	PPO OPTION Out-of-Network
	<i>The Plan Pays:</i>	<i>The Plan Pays:</i>	<i>The Plan Pays:</i>
Chiropractic Care Note: Coverage for up to a maximum of 40 visits per Plan year.	90% of NR; subject to deductible and \$20 per visit co-payment	80% of NR; subject to deductible and \$20 per visit co-payment	60% of OONR; subject to deductible
Transplant Services	90% of NR; subject to deductible at Unicare contracted network facility	90% of NR; subject to deductible at Unicare contracted network facility	60% of NR; subject to deductible and balance billing
	Note: Services provided through Unicare Centers of Excellence for PPO and Indemnity.		

IMPORTANT PPO AND INDEMNITY CONSIDERATIONS

See the Summary Plan Description and *Updaters* for coverage details, including limitations and exclusions.

- ▶ Charges from non-participating providers are subject to balance billing. These charges are the member's responsibility and do not count toward deductibles or out-of-pocket spending limits.
- ▶ Services covered under the PPO from an In-Network/Georgia provider will apply only to the In-Network/Georgia deductible and out-of-pocket limit.
- ▶ Services covered under the PPO from In-Network/Out-of-State and Out-of-Network providers apply to the same deductible.
- ▶ Lifetime benefit maximums are combined totals among the PPO Options, Indemnity Option and HMO Options (except Kaiser Permanente).
- ▶ Some PPO annual maximums and limitations are combined totals.
- ▶ Annual dollar and visit limitations, deductibles and out-of-pocket spending limits are based on a July 1 to June 30 Plan year.
- ▶ Some services may require MCP precertification, prior approval or letters of medical necessity before such services are covered.
- ▶ Co-payments do not apply toward deductibles or out-of-pocket limits unless otherwise noted.
- ▶ Exclusions and limitations vary among Plan options. Contact specific Plan option for more information.

* NR = Network Rate for in-network PPO services
 OONR = Out-of-Network Rate for out-of-network PPO services
 IR = Indemnity Rate for Indemnity services

INDEMNITY OPTIONS

BASIC AND PREMIER
<i>The Plan Pays:</i>
90% of IR; subject to deductible
90% of NR at contracted facility; 60% NR subject to \$100 hospital deductible

Note: PPO note to the left also applies here.

HMO OPTIONS

BLUECHOICE	CIGNA	KAISER PERMANENTE	UNITEDHEALTHCARE
<i>The Plan Pays:</i>	<i>The Plan Pays:</i>	<i>The Plan Pays:</i>	<i>The Plan Pays:</i>
100% after \$20 co-payment per visit; limited to 20 visits per Plan year	100% after \$20 co-payment per visit; limited to 20 visits per Plan year	100% after \$20 co-payment per visit; limited to 20 visits per Plan year	100% after \$20 co-payment per visit; limited to 20 visits per Plan year
100%	100%	100%	100%

IMPORTANT HMO CONSIDERATIONS

- ▶ Annual dollar and visit limitations are based on a July 1 to June 30 Plan year.
- ▶ Some services may require prior authorization by the HMO before such services are covered. Also, some services may have limitations not contained in this summary.
- ▶ Most HMOs require the selection of a primary care physician (PCP) to manage your care. Failure to specify a PCP could delay receipt of your ID card. However, in some instances the HMO assigns you a PCP located near your residence if a PCP is not specified. Note: UnitedHealthcare does not require the selection of a PCP.
- ▶ Most HMOs require you to obtain referrals to see most specialists. Failure to obtain a referral could result in denial of your claim. Note: UnitedHealthcare does not require a referral for coverage of specialist services.
- ▶ Contact the HMO directly for more details regarding covered services, exclusions and limitations.



PHARMACY

BENEFIT OPTIONS

- ▶ PPO Basic
- ▶ PPO Premier
- ▶ PPO Choice Basic
- ▶ PPO Choice Premier
- ▶ Indemnity Basic
- ▶ Indemnity Premier

WHAT ARE THE DIFFERENCES BETWEEN THE BASIC AND PREMIER PHARMACY OPTIONS?

There are three differences between the Basic and Premier prescription benefits:

- ▶ The Basic Preferred Drug List (PDL) is not as extensive as the Premier Preferred Drug List;
- ▶ The co-payments are different (see the Pharmacy Benefit Comparison chart on the next page); and
- ▶ There are no Maximum Out-of-Pocket (MOP) limits for the Basic Pharmacy Options. (see the Pharmacy Benefit Comparison chart)

Before making your choice, review the PPO, PPO Choice, Indemnity Plan Overviews and the Pharmacy Benefit Comparison chart.

PLAN PROVISIONS FOR THE BASIC AND PREMIER OPTIONS

Progressive Drug Management Program (PDMP)

This program has been designed to assist your doctor in finding the most appropriate drug treatment for you and your family. The first step in the program is usually a proven less expensive treatment known to be safe and effective for most people. If the drug does not work for you, your doctor may progress to another drug. A Prior Authorization may be required as the next step in the program to obtain the drug that is best suited for you. Progressive Drug Management helps to ensure that you are receiving the most appropriate and cost effective drug for your condition. The PDMP is in effect for the following therapeutic categories: ACE Inhibitors, Brand NSAID, Elidel/Protopic and Glucophage XR. *Note: This list is subject to change during the Plan year.*

Note: If you should go to the pharmacy and are told that your prescription cannot be filled because a prior authorization is required, please have your doctor call with your clinical information to Express Scripts, Inc.'s (ESI's) prior authorization unit. The prior authorization process is a telephonic process where your doctor can give your clinical information over the phone for review. If the information provided by your doctor does not meet the criteria for the drug requested, you are entitled to appeal. Your physician will need to fax a written request to ESI's appeals unit that should include your medical history and all previously used drugs to treat your particular condition.

HEALTH MAINTENANCE ORGANIZATIONS (HMOs)

- ▶ Generic co-payments are different from the PPO and Indemnity Plan Options
- ▶ No Maximum Out-of-Pocket (MOP) limit feature
- ▶ Maintenance Drugs may be obtained for up to a 90-day supply of your prescription(s) for two (2) co-payments. *Note:* Kaiser: one co-payment per 30-day supply.
- ▶ Contact respective HMO for further Plan provisions. See the inside cover for telephone numbers and Web site addresses.

ALL PLAN OPTIONS

- ▶ **No co-payments for drugs that are covered by the SHBP will be changed or overridden on an individual basis.**
- ▶ In addition, many drugs listed as non-preferred have a generic or preferred brand-name drug alternative. Preferred drug alternatives are therapeutically equivalent while being more cost effective.
- ▶ If the drug cost is less than the co-payment, you do not pay the co-payment but the lesser of, which is the actual cost of the drug. For example, if the preferred drug cost is \$18.23, and the preferred drug co-payment is \$25.00, you will only pay \$18.23.

PHARMACY BENEFIT COMPARISON CHART							
PLAN TYPE	PREFERRED DRUG LIST (PDL)	GENERIC Co-Payment		PREFERRED BRAND Co-Payment		NON-PREFERRED BRAND Co-Payment	QUARTERLY MAXIMUM Out-of-Pocket (MOP)
PPO Basic PPO Choice Basic	Basic (see page 28 for abbreviated PDL)	\$10		\$25		\$40	Does not apply
Indemnity Basic	Basic (see page 28 for abbreviated PDL)	\$10		\$25		\$40	Does not apply
PPO Premier PPO Choice Premier	Premier (see page 29 for abbreviated PDL)	\$15		\$25		*20% of cost; minimum \$40, maximum \$100	\$450 per member, \$1,300 family
Indemnity Premier	Premier (see page 29 for abbreviated PDL)	\$15		\$25		*20% of cost; minimum \$40, maximum \$100	\$450 per member, \$1,300 family
HMO's – BlueChoice CIGNA UnitedHealthcare	HMO Drug List	\$10		\$25		\$40	Does not apply
Kaiser Permanente	Kaiser Drug List	Kaiser facility \$10	Eckerd Drugs \$16	Kaiser facility \$25	Eckerd Drugs \$31	Does not apply	Does not apply

***Note: The Non-Preferred Brand Co-Payment does not apply to the Quarterly Maximum Out-of-Pocket.**
Please contact each HMO regarding pharmacy lists — BlueChoice (800) 464-1367; CIGNA (800) 564-7642; Kaiser Permanente (800) 611-1811; UnitedHealthcare (866) 527-9599.

BASIC AND PREMIER PREFERRED DRUG LISTS

- ▶ The pharmacy drug lists are created, reviewed and continually updated by a team of healthcare professionals including physicians and pharmacists.
- ▶ A medication becomes a preferred drug based first on efficacy, then safety and last on cost-effectiveness.
- ▶ Your doctor can use the list associated with your chosen option to select medications for your healthcare needs, while helping you maximize your prescription drug benefit. The choice of medications is strictly between you and your doctor.
- ▶ Preferred Drug Lists for the SHBP members are subject to change. Prior to purchasing your medication(s) you may view the drug lists at www.dch.state.ga.us or contact Express Scripts by phone at (877) 650-9342 or TDD (800) 842-5754 to get the most current status on any covered drug. On the following pages is an abbreviated version of the two drug lists for comparison. Use these lists to help you determine what your co-payments will be and to evaluate which drug benefit will best meet your needs.

GEORGIA BASIC PREFERRED DRUG LIST (ABBREVIATED)

EFFECTIVE JULY 1, 2004

FOR STATE HEALTH BENEFIT PLAN – PPO AND INDEMNITY HEALTH PLANS

All generics are considered preferred drugs (examples listed in each category). If at any time during the Plan year a brand has a generic equivalent become available, that brand will automatically be moved to the non-preferred status.

KEY

PA – prior authorization required
 QLL – quantity or therapy limits exist

ALLERGY/RESPIRATORY

ADVAIR DISKUS, QLL
 albuterol generic, QLL
 ALLEGRA, -D, QLL
 COMBIVENT, QLL
 FLOVENT ROTADISK, QLL
 FORADIL, QLL
 INTAL, QLL
 ipratropium generic, QLL
 PROVENTIL HFA, QLL
 QVAR, QLL
 SEREVENT DISKUS, QLL
 SINGLAIR

ANTI-INFECTIVES

acyclovir generic
 amoxicillin generic
 amoxicillin/clavulanic generic
 ampicillin generic
 AUGMENTIN ES
 AUGMENTIN XR, QLL
 AVELOX, ABC PACK
 cefuroxime generic
 cephalixin generic
 CIPRO
 DIFLUCAN, PA
 doxycycline generic
 erythromycin generic
 ketoconazole generic
 nitrofurantoin generic
 penicillin generic
 SPORANOX, QLL, PA
 TEQUIN
 tetracycline generic
 timethoprim generic
 tmp/smx generic
 ZITHROMAX

AUTONOMIC & CNS

AMBIEN, QLL
 amitriptyline generic
 CELEXA
 CONCERTA
 dextroamphetamine generic,
 PA age > 21
 EFFEXOR, -XR
 fluoxetine generic
 IMITREX, QLL
 LEXAPRO
 METADATE CD
 methylphenidate generic
 mirtazapine generic
 paroxetine generic
 PAXIL CR
 REMERON soltab
 SONATA, QLL
 STRATTERA
 temazepam generic
 trazodone generic
 WELLBUTRIN SR
 ZOMIG, -ZMT, QLL

GASTROINTESTINAL

ASACOL
 cimetidine generic
 famotidine generic
 nizatidine generic
 omeprazole generic, QLL, PA
 PENTASA
 PREVACID, QLL, PA
 PREVPAC, QLL
 ranitidine generic
 sulfasalazine generic

CARDIOVASCULAR

ADVICOR
 atenolol generic
 AVALIDE
 AVAPRO
 bisoprolol generic
 bisoprolol w/hctz generic
 chlorthalidone generic
 clonidine generic
 COREG
 CRESTOR
 diltiazem, er generic
 DIOVAN, HCT
 enalapril generic
 enalapril w/hctz generic
 gemfibrozil generic
 hydrochlorothiazide generic
 INNOPRAN XL
 LIPITOR
 lisinopril generic
 lisinopril w/hctz generic
 LOTENSIN HCT
 LOTREL
 lovastatin generic
 metoprolol tartrate generic
 moexipril generic
 NIASPAN
 nifedipine er generic
 NORVASC
 propranolol generic
 terazosin generic
 verapamil generic
 verapamil, xr generic
 ZAROXOLYN
 ZETIA, PA

ENDOCRINE

ACTONEL, QLL
 ACTOS, QLL
 AVANDAMET
 AVANDIA, QLL
 DIDRONEL
 EVISTA
 FORTEO, PA
 FOSAMAX, QLL
 glipizide generic

glyburide generic
 HUMALOG
 HUMULIN
 LANTUS
 metformin generic
 NOVOLIN
 NOVOLOG
 PRANDIN
 PRECOSE
 STARLIX
 tolazamide generic
 tolbutamide generic

OBSTETRICAL/ GYNECOLOGICAL

ESCLIM, QLL
 estradiol generic
 FEMHRT
 medroxyprogesterone generic
 ORTHO EVRA, QLL
 ORTHO TRI-CYCLEN LO
 PREMARIN
 PREMPHASE
 PREMPRO
 YASMIN

EAR-NOSE-THROAT

ASTELIN, QLL
 FLONASE, QLL
 NASONEX, QLL

UROLOGICAL

DETROL, -LA
 oxybutynin generic
 AVODART
 EDEX, QLL, PA
 FLOMAX
 VIAGRA, QLL, PA

MUSCULOSKELETAL

diclofenac sodium generic
 ibuprofen generic
 indomethacin generic
 nabumetone generic
 naproxen generic
 VIOXX, QLL
 choline mag trisalicylate
 generic
 diflunisal generic
 salsalate generic

ALTERNATIVE PRODUCT LISTING FOR NON-PREFERRED BRANDS

NON-PREFERRED BRAND	SELECTED ALTERNATIVE BRANDS
Accolate	Singulair
Accupril	lisinopril
Aciphex	omeprazole, Prevacid
Activella	FemHRT, Prempro, Premphase
Altace	lisinopril
Atacand	Avapro, Diovan
Biaxin, -XL	erythromycin, Zithromax
Clarinex	Allerga
Cozaar	Avapro, Diovan
Hyzaar	Avalide, Diovan HCT
Maxalt, -MLT	Imitrex, Zomig, -ZMT
Mobic	generic NSAIDs
Nexium	omeprazole, Prevacid
Plendil	nifedipine, Norvasc
Protonix	omeprazole, Prevacid
Pulmicort	Flovent, QVAR
Sular	nifedipine, Norvasc
Zocor	lovastatin, Crestor, Lipitor
Zoloft	fluoxetine, paroxetine, Lexapro, Paxil CR
Zyrtec	Allegra

For Prior Authorizations (PA), Quantity Level Limits (QLL) or any questions regarding specific coverage rules or co-payment information for drugs not listed on this document, please contact Express Scripts, Inc. at 1-877-650-9342.

GEORGIA *PREMIER* PREFERRED DRUG LIST (ABBREVIATED)

EFFECTIVE JULY 1, 2004

FOR STATE HEALTH BENEFIT PLANS – PPO AND INDEMNITY HEALTH PLANS

All generics are considered preferred drugs (examples listed in each category). If at any time during the Plan year a brand has a generic equivalent become available, that brand will automatically be moved to the non-preferred status.

KEY

PA – prior authorization required
 QLL – quantity or therapy limits exist

ALLERGY/RESPIRATORY

ADVAIR DISKUS, QLL
 albuterol generic, QLL
 ALLEGRA, -D, QLL
 COMBIVENT, QLL
 cromolyn sodium generic
 FLOVENT, -ROTADISK, QLL
 FORADIL, QLL
 ipratropium generic, QLL
 MAXAIR AUTOHALER, QLL
 metaproterenol generic, QLL
 PROVENTIL HFA, QLL
 PULMICORT RESPULES, QLL
 SINGULAIR
 TILADE, QLL
 ZYRTEC, QLL

ANTI-INFECTIVES

acyclovir generic
 amoxicillin generic
 amoxicillin/clavulanic generic
 ampicillin generic
 AUGMENTIN ER
 AUGMENTIN XR, QLL
 AVELOX
 cefuroxime generic
 CEFZIL
 cephalixin generic
 CIPRO
 CIPRO XR, QLL
 DIFLUCAN 150MG, QLL
 DIFLUCAN, PA
 doxycycline generic
 erythromycin generic
 GANTRISIN PEDIATRIC
 griseofulvin generic
 ketoconazole generic
 LAMISIL, PA
 MACROBID
 penicillin generic
 SPECTRACEF
 SPORANOX QLL, PA
 tetracycline generic
 tmp/smx generic
 VALTrex, QLL
 ZITHROMAX

AUTONOMIC & CNS

ADDERALL XR, PA age >21
 alprazolam generic
 AMBIEN, QLL
 amitriptyline generic
 bupropion generic
 buspirone generic
 CONCERTA
 desipramine generic
 dextroamphetamine generic,
 PA age >21
 diazepam generic
 EFFEXOR, -XR
 fluoxetine generic
 imipramine generic
 IMITREX, QLL
 LEXAPRO
 lorazepam generic
 MIGRANAL, QLL
 nortriptyline generic
 oxazepam generic
 paroxetine generic
 trazodone generic
 triazolam generic

WELLBUTRIN-XL
 ZOLOFT
 ZOMIG, -ZMT, QLL

GASTROINTESTINAL

ASACOL
 AZULFIDINE EN-TAB
 cimetidine generic
 famotidine generic
 omeprazole generic QLL, PA
 PANCREASE
 pancrelipase generic
 PENTASA
 PREVACID QLL, PA
 PREVPAC, QLL
 PROCTOFOAM-HC
 ranitidine generic
 ROWASA
 sucralfate generic
 URSO
 VIOKASE
 ZANTAC SYRUP

CARDIOVASCULAR

ADVICOR
 ALTACE
 atenolol generic
 benazepril generic
 benazepril/hctz generic
 captopril generic
 CARDIZEM LA
 CATAPRES-TTS, QLL
 cholestyramine generic
 COREG
 COZAAR
 diltiazem, sa generic
 DIOVAN, -HCT
 enalapril generic
 furosemide generic
 gemfibrozil generic
 hydrochlorothiazide generic
 HYZAAR
 LEVATOL
 LEXXEL
 LIPITOR
 lisinopril generic
 lisinopril w/hctz generic
 LOTREL
 lovastatin generic
 metolazone generic
 metoprolol generic
 NIASPAN
 nicardipine generic
 nifedipine, er, xl generic
 NIMOTOP
 NORVASC
 PRAVACHOL
 prazosin generic
 propranolol generic
 spironolactone generic
 terazosin generic
 TOPROL XL
 torsemide generic
 TRICOR
 verapamil, xr generic
 ZOCOR

ENDOCRINE

ACTOS, QLL
 AMARYL
 AVANDIA, QLL

DDAVP NASAL
 EVISTA
 FOSAMAX, QLL
 glipizide er generic
 glyburide micronized generic
 GLYSET
 HUMALOG
 HUMULIN
 LANTUS
 metformin
 MIACALCIN
 NOVOLIN
 NOVOLOG
 PRANDIN
 PRECOSE
 STARLIX
 tolazamide generic
 tolbutamide generic

OBSTETRICAL/ GYNECOLOGICAL

COMBIPATCH
 ESTRADERM PATCH, QLL
 ESTRATEST, -HS
 estradiol patch generic, QLL
 estropiate generic
 ESTROSTEP FE
 FEMHRT
 medroxyprogesterone generic
 MENEST
 NUVARING
 ORTHO EVRA, QLL
 ORTHO TRI-CYCLEN LO
 PREMARIN
 PREMPHASE

PREMPRO
 VIVELLE, -DOT, QLL

EAR-NOSE-THROAT

ASTELIN, QLL
 FLONASE AQ, QLL
 NASONEX, QLL

UROLOGICAL

DETROL, -LA
 DITROPAN XL
 EDEX QLL, PA
 FLOMAX
 oxybutynin generic
 PRESCAR
 VIAGRA QLL, PA

MUSCULOSKELETAL

ARTHROTEC
 CELEBREX, QLL
 diclofenac generic
 fenoprofen generic
 flurbiprofen generic
 indomethacin generic
 ketoprofen generic
 meclufenamate generic
 nabumetone generic
 naproxen generic
 piroxicam generic
 sulindac generic
 tolmetin generic
 VIOXX, QLL

ALTERNATIVE PRODUCT LISTING FOR NON-PREFERRED BRANDS

NON-PREFERRED BRAND	SELECTED ALTERNATIVE BRANDS
Aceon	benazepril, lisinopril, Altace
Aciphex	omeprazole, Prevacid
Accolate	Singulair
Accupril	benazepril, lisinopril, Altace
Activella	Prempro, Premphase
Actonel	Fosamax, Miacalcin
Atacand	Cozaar, Diovan
Biaxin, -XL	erythromycin, Zithromax
Celexa	fluoxetine, paroxetine, Lexapro, Zoloft
Clarinet	Allerga, Zyrtec
Lescol, -XL	lovastatin, Lipitor, Pravachol, Zocor
Mavik	benazepril, lisinopril, Altace
Maxalt, -MLT	Imitrex, Zomig, -ZMT
Mobic	generic NSAIDs
Nexium	omeprazole, Prevacid
Plendil	nifedipine, Norvasc
Protonix	omeprazole, Prevacid
Pulmicort	Flovent
Serevent	Foradil
Sular	nifedipine, Norvasc
Teveten	Cozaar, Diovan

For Prior Authorizations (PA), Quantity Level Limits (QLL) or any questions regarding specific coverage rules or co-payment information for drugs not listed on this document, please contact Express Scripts, Inc. at 1-877-650-9342.



SERVICE AREAS

FOR YOUR HEALTH PLAN OPTIONS

SERVICE AREAS

Service areas are State-approved geographic areas, such as counties or zip codes, where providers participate in the network offered by the Plan option in which you have enrolled.

PPO AND PPO CHOICE OPTIONS – BASIC AND PREMIER

Georgia Service Area

The Georgia service area includes the state of Georgia and the border communities of the Chattanooga, Tennessee area, including Bradley County; and Phenix City, Alabama. The zip code area in which you **receive a service** is used to determine whether or not you are in the Georgia service area. If you receive covered services from a 1st Medical Network provider located in one of the zip codes to the right, you receive the highest level of coverage available in the PPO Options.

Out-of-State/National Service Area

The out-of-state service area includes all national locations outside of the Georgia service area described to the right. By using Beech Street providers outside of the Georgia service area, you are protected against balance billing (being charged more than what the Plan allows). However, use of Beech Street providers inside the Georgia service area is considered out-of-network care with lower levels of coverage and separate deductibles, unless the provider also is a 1st Medical Network participant.

GEORGIA:

All counties; all zip codes

ALABAMA:

Russell County (Phenix City area): 36851, 36856, 36858, 36859, 36860, 36867, 36868, 36869, 36870, 36871 and 36875.

TENNESSEE:

Bradley County (Cleveland area): 37310, 37311, 37312, 37320, 37323, 37353 and 37364.

Hamilton County (Chattanooga area): 37302, 37304, 37308, 37315, 37341, 37343, 37350, 37351, 37363, 37373, 37377, 37379, 37384, 37401, 37402, 37403, 37404, 37405, 37406, 37407, 37408, 37409, 37410, 37411, 37412, 37414, 37415, 37416, 37419, 37421, 37422, 37424 and 37450.

HMO OPTIONS

You must live or work in the HMO's approved service area to be eligible for coverage under that option. Below are the HMO Option service areas by county. If you live or work in a county marked "Yes" under any of the HMOs listed, you may enroll in that HMO. If the county where you live or work is not listed below, you are not eligible for HMO coverage.

COUNTY OF RESIDENCE	BLUECHOICE	CIGNA	KAISER PERMANENTE	UNITEDHEALTHCARE
Appling	Not Available	Yes	Not Available	Yes
Atkinson	Not Available	Not Available	Not Available	Yes
Bacon	Not Available	Yes	Not Available	Yes
Banks	Yes	Not Available	Not Available	Yes
Barrow	Yes	Yes	Yes	Yes
Bartow	Yes	Yes	Yes	Yes
Ben Hill	Not Available	Not Available	Not Available	Yes
Berrien	Not Available	Not Available	Not Available	Yes
Bibb	Yes	Yes	Not Available	Yes
Bleckley	Yes	Yes	Not Available	Yes
Brooks	Not Available	Not Available	Not Available	Yes
Bryan	Yes	Yes	Not Available	Yes
Bulloch	Yes	Yes	Not Available	Yes
Burke	Yes	Yes	Not Available	Yes
Butts	Yes	Yes	Yes	Yes
Candler	Not Available	Yes	Not Available	Yes
Carroll	Yes	Not Available	Not Available	Yes
Catoosa	Not Available	Yes	Not Available	Yes
Chatham	Yes	Yes	Not Available	Yes
Chattahoochee	Yes	Not Available	Not Available	Yes
Chattooga	Yes	Yes	Not Available	Yes
Cherokee	Yes	Yes	Yes	Yes
Clarke	Yes	Yes	Not Available	Yes
Clayton	Yes	Yes	Yes	Yes
Clinch	Not Available	Not Available	Not Available	Yes

COUNTY OF RESIDENCE	BLUECHOICE	CIGNA	KAISER PERMANENTE	UNITEDHEALTHCARE
Cobb	Yes	Yes	Yes	Yes
Colquitt	Not Available	Not Available	Not Available	Yes
Columbia	Yes	Yes	Not Available	Yes
Cook	Not Available	Not Available	Not Available	Yes
Coweta	Yes	Yes	Yes	Yes
Crawford	Yes	Not Available	Not Available	Yes
Dade	Not Available	Yes	Not Available	Yes
Dawson	Yes	Not Available	Not Available	Yes
Decatur	Not Available	Not Available	Not Available	Yes
DeKalb	Yes	Yes	Yes	Yes
Douglas	Yes	Yes	Yes	Yes
Early	Not Available	Not Available	Not Available	Yes
Echols	Not Available	Not Available	Not Available	Yes
Effingham	Yes	Yes	Not Available	Yes
Elbert	Yes	Yes	Not Available	Yes
Emanuel	Yes	Yes	Not Available	Yes
Evans	Not Available	Yes	Not Available	Yes
Fayette	Yes	Yes	Yes	Yes
Floyd	Yes	Yes	Not Available	Yes
Forsyth	Yes	Yes	Yes	Yes
Franklin	Yes	Yes	Not Available	Not Available
Fulton	Yes	Yes	Yes	Yes
Gilmer	Yes	Not Available	Not Available	Not Available
Glascok	Yes	Not Available	Not Available	Yes
Gordon	Yes	Yes	Not Available	Yes
Grady	Not Available	Not Available	Not Available	Yes
Greene	Yes	Yes	Not Available	Yes
Gwinnett	Yes	Yes	Yes	Yes
Habersham	Not Available	Not Available	Not Available	Yes
Hall	Yes	Yes	Yes	Yes
Harris	Yes	Yes	Not Available	Yes
Hart	Yes	Not Available	Not Available	Not Available
Heard	Yes	Not Available	Not Available	Not Available
Henry	Yes	Yes	Yes	Yes

COUNTY OF RESIDENCE	BLUECHOICE	CIGNA	KAISER PERMANENTE	UNITEDHEALTHCARE
Houston	Yes	Not Available	Not Available	Yes
Jackson	Yes	Yes	Not Available	Yes
Jasper	Not Available	Not Available	Not Available	Yes
Jefferson	Yes	Yes	Not Available	Yes
Jenkins	Yes	Not Available	Not Available	Yes
Johnson	Yes	Not Available	Not Available	Yes
Jones	Yes	Yes	Not Available	Yes
Lamar	Not Available	Yes	Not Available	Yes
Lanier	Not Available	Not Available	Not Available	Yes
Laurens	Not Available	Yes	Not Available	Yes
Liberty	Yes	Yes	Not Available	Yes
Lincoln	Yes	Yes	Not Available	Yes
Long	Not Available	Yes	Not Available	Yes
Lowndes	Not Available	Not Available	Not Available	Yes
Lumpkin	Yes	Not Available	Not Available	Yes
Madison	Yes	Yes	Not Available	Yes
Marion	Yes	Yes	Not Available	Yes
McDuffie	Yes	Yes	Not Available	Yes
Meriwether	Yes	Not Available	Not Available	Yes
Mitchell	Not Available	Not Available	Not Available	Yes
Monroe	Yes	Yes	Not Available	Yes
Morgan	Yes	Not Available	Not Available	Yes
Muscogee	Yes	Yes	Not Available	Yes
Newton	Yes	Yes	Yes	Yes
Oconee	Yes	Yes	Not Available	Yes
Oglethorpe	Yes	Yes	Not Available	Yes
Paulding	Yes	Yes	Yes	Yes
Peach	Yes	Not Available	Not Available	Yes
Pickens	Yes	Not Available	Not Available	Yes
Pierce	Not Available	Not Available	Not Available	Yes
Pike	Not Available	Yes	Not Available	Yes
Polk	Yes	Yes	Not Available	Yes
Pulaski	Yes	Not Available	Not Available	Yes
Putnam	Not Available	Not Available	Not Available	Yes

COUNTY OF RESIDENCE	BLUECHOICE	CIGNA	KAISER PERMANENTE	UNITEDHEALTHCARE
Richmond	Yes	Yes	Not Available	Yes
Rockdale	Yes	Yes	Yes	Yes
Screven	Not Available	Yes	Not Available	Yes
Seminole	Not Available	Not Available	Not Available	Yes
Spalding	Yes	Yes	Yes	Yes
Stephens	Not Available	Not Available	Not Available	Yes
Stewart	Yes	Not Available	Not Available	Yes
Talbot	Yes	Not Available	Not Available	Yes
Taliaferro	Not Available	Not Available	Not Available	Yes
Tattnall	Not Available	Yes	Not Available	Yes
Taylor	Not Available	Yes	Not Available	Yes
Thomas	Not Available	Not Available	Not Available	Yes
Tift	Not Available	Not Available	Not Available	Yes
Toombs	Not Available	Not Available	Not Available	Yes
Troup	Not Available	Not Available	Not Available	Yes
Turner	Not Available	Not Available	Not Available	Yes
Twiggs	Yes	Not Available	Not Available	Yes
Upson	Not Available	Not Available	Not Available	Yes
Walker	Not Available	Yes	Not Available	Yes
Walton	Yes	Yes	Yes	Yes
Ware	Not Available	Not Available	Not Available	Yes
Warren	Yes	Not Available	Not Available	Yes
Washington	Yes	Not Available	Not Available	Not Available
Wayne	Not Available	Not Available	Not Available	Yes
White	Yes	Not Available	Not Available	Yes
Whitfield	Not Available	Yes	Not Available	Yes
Wilkes	Yes	Yes	Not Available	Yes
Wilkinson	Yes	Yes	Not Available	Yes
Worth	Not Available	Not Available	Not Available	Yes



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 enroll in the SHBP.

The PPO, PPO Choice and Indemnity Options (Basic and Premier) contain a pre-existing condition (PEC) limitation. Specifically, the Health Plan will not pay charges that are over \$1,000 for the treatment of any pre-existing condition during the first 12 months of a patient's coverage, unless the patient gives satisfactory documentation that he or she has been free of treatment or medication for that condition for at least six consecutive calendar months. If you are enrolling as a new hire, this 12-month period begins on your hire date. However, a pre-existing condition limitation does not apply to coverage for:

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

In certain situations, SHBP members and dependents can reduce the 12-month pre-existing condition limitation period. The reduction is possible by using what is called "creditable coverage" to offset a pre-existing condition period. Creditable coverage generally includes the health coverage 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 pre-existing condition 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 your first day of 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 pre-existing condition limitation period for your dependents (including your spouse), you must provide the SHBP with a certificate of creditable coverage stating when coverage started and ended for each dependent that you want to cover. Again, 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 a 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 former employer(s) to offset the pre-existing condition limitation period under the SHBP. The SHBP will evaluate your 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 your 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.



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 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 claim administrator for payment, the claims include your diagnoses and the medical treatments you received. For some medical treatments, your healthcare 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.state.ga.us (click on "Privacy").

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.state.ga.us (click on "Privacy"). This notice is effective April 14, 2003.



HOW DCH USES AND DISCLOSES HEALTHCARE INFORMATION

There are some services the Plan provides through contracts with private companies. For example, Blue Cross and Blue Shield of Georgia 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 HEALTHCARE 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.

FOR MORE INFORMATION AND 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) 331-2867.
- ▶ You also may contact the HHS Office for Civil Rights by calling (866) OCR-PRIV (866) 627-7748 or (886) 788-4989 TTY.

There will be no retaliation for filing a complaint.

▶ WOMEN'S HEALTH & CANCER RIGHTS ACT

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

Following cancer surgery, the SHBP covers:

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

Note: Reconstructive surgery requires prior approval and all inpatient admissions require MCP precertification.

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.

▶ PENALTIES FOR MISREPRESENTATION

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

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

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.

