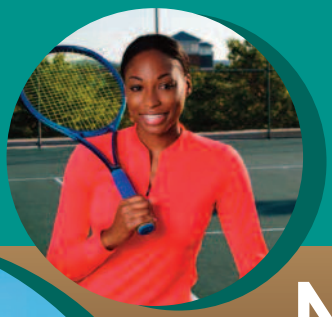
SHBP
State Health Benefit Plan





NEW ENROLLEE DECISION GUIDE 2012





Are you engaged in your health?

Plan Year January 1 — December 31, 2012

www.myshbp.ga.gov

ADDITIONAL HELP/CONTACT INFORMATION

State Health Benefit Plan (SHBP): www.myshbp.ga.gov

Vendor	Member Services	Website
CIGNA HRA, HDHP hours 24/7	800-633-8519 TDD 800-576-1314	www.mycigna.com/shbp
UnitedHealthcare HRA HDHP hours 8 a.m. – 8 p.m. local time zone; 7 days a week, TTY 711	800-396-6515 877-246-4189	www.welcometouhc.com/shbp
PeachCare for Kids®	877-427-3224	www.peachcare.org
TRICARE Supplement	866-637-9911	www.asicorporation.com
SHBP Eligibility	800-610-1863	www.myshbp.ga.gov

PENALTIES FOR MISREPRESENTATION

If an SHBP participant misrepresents eligibility information when applying for coverage, during change of coverage or when filing for benefits, the SHBP may take adverse action against the participant, including but not limited to terminating coverage (for the participant and his or her dependents) or imposing liability to the SHBP for fraud or indemnification (requiring payment for benefits to which the participant or his or her beneficiaries were not entitled). Penalties may include a lawsuit, which may result in payment of charges to the Plan or criminal prosecution in a court of law. In order to avoid enforcement of the penalties, the participant must notify the SHBP immediately if a dependent is no longer eligible for coverage or if the participant has questions or reservations about the eligibility of a dependent. This policy may be enforced to the fullest extent of the law.

Georgia Department of Community Health

David A. Cook, Commissioner Nathan Deal, Governor

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

Dear State Health Benefit Plan (SHBP) Member:

Welcome to the State Health Benefit Plan (SHBP). The SHBP is committed to providing high-quality health benefits at an affordable price to its members. SHBP's goal is to assure that all members receive the best possible health care insurance coverage at affordable costs while keeping members as healthy as possible by encouraging them to lead a healthy lifestyle.

Upon joining SHBP, new enrollees have the opportunity to choose between two consumer-driven health options, each offered by CIGNA Healthcare and UnitedHealthcare. These plans are:

- Standard HDHP
- Standard HRA

For those members enrolled in TRICARE, the TRICARE supplement plan option is also available.

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

If you choose to take advantage of the HRA, you will have the extra benefit of the SHBP contributing dollars to your HRA on an annual basis for treatment of medical and pharmacy expenses.

Please read the New Enrollee Decision Guide carefully to learn about the plans available to you. Additional information and tools are available at www.myshbp.ga.gov.

The Georgia Department of Community Health, which administers the SHBP, is committed to providing you with meaningful and affordable options as well as the tools to help you and your family members stay healthy.

Sincerely,

David A. Cook
Commissioner

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Listed below are common health care acronyms that are used throughout this decision guide.

CDHP – Consumer-Driven Health Plan

CMS – Centers for Medicare and Medicaid Services

COB – Coordination of Benefits

DCH – Georgia Department of Community Health

FSA – Flexible Spending Account

HDHP – High Deductible Health Plan

HMO – Health Maintenance Organization

HRA – Health Reimbursement Arrangement

HSA – Health Savings Account

MA (PPO) – Medicare Advantage Preferred Provider Organization

OE – Open Enrollment

PCF – Personalized Change Form

PCP – Primary Care Physician

ROCP – Retiree Option Change Period

SHBP – State Health Benefit Plan

SPC – Specialist

SPD – Summary Plan Description

UHC – UnitedHealthcare

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

GENERAL INFORMATION

This guide will provide you with a brief explanation of each Plan Option.

While CIGNA and UnitedHealthcare's basic plan design is the same for each option, each vendor has nuances in benefits and services that are unique to each option. It is important that you read the Decision Guide so you will understand what these differences are and how they may affect you.

STATE HEALTH BENEFIT PLAN

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

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

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

WHAT CAN YOU DO TO HELP MANAGE YOUR HEALTH CARE COSTS?

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

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

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

Steps you can take include:

- Keep a list of all medications you take.
- Shop in-network providers and pharmacies.
- Find out what your drugstore charges for a drug.
- Make sure all procedures are pre-certified, if required.
- Make sure you get the results of any test or procedure.
- Understand what will happen if you need surgery.
- Check your Explanation of Benefits (if provided under your plan option) and if you have questions, 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.

GEORGIA STATISTICS SHOW HOW OUR CHOICES MAY BE AFFECTING OUR HEALTH

- 27% of adults are obese, which increases the risk of cardiovascular disease.
- Cardiovascular Disease (CVD) accounted for one third (32%) - 21,389 CVD deaths in 2007.
- Adults with high blood pressure has increased from 21% in 1997 to 30% in 2007.
- Adults with high cholesterol has increased from 24% in 1997 to 37% in 2007.
- Adults reported having diabetes increased from 6% in 1998 to 10% in 2008.
- The majority (75%) of adults did not consume the recommended five or more servings of fruits and vegetables per day in 2007.

What Can I Do for My Health and Wellness?

- Utilize the Preventive Health and Wellness Services.
- Use the Nurse Advice Line.
- Use Vendor Online Tools -There is a wealth of information available at your fingertips online.

  —You can compare prescription drug costs

  —You can access health coaching programs
- You can locate a premier doctor if you are having surgery.
- You can locate a doctor in the network.
- You can review the status of claims and review benefits.
- You can track your balances in the HRA.
- Order an ID card.

To learn more about these and other helpful tools and resources go to www.mycigna.com and www.welcometouhc.com/shbp.

TAKE STEPS TO GET HEALTHY
Online and Telephonic Coaching Programs and Resources Available to You Through the Vendors

Biometric Screening	*Weight Management*	*Exercise*	*Stress*	*Heart Health*	*Diabetes*	*Nutrition*
Cholesterol				X		X
Blood Sugar	X	X			X	X
Blood Pressure	X		X	X		
Body Mass Index (BMI)	X	X		X	X	X

SHBP ELIGIBILITY INFORMATION

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

SHBP ELIGIBILITY FOR YOU

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

- **A full-time employee of the state of Georgia, the Georgia General Assembly, or an agency, board, commission, department, county administration or contracting employer that participates in the SHBP, as long as:**
  - – You work at least 30 hours a week consistently, and
  - – Your employment is expected to last at least nine months.

  Not eligible: Student employees or seasonal, part-time or short-term employees.
- **A certified public school teacher or library employee** who works half-time or more, but not less than 17.5 hours a week

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

SHBP ELIGIBILITY FOR YOUR DEPENDENTS

The SHBP covers dependents who meet SHBP guidelines. Eligibility documentation must be submitted before SHBP can send notification of a dependent's coverage to the health care vendors.

Eligible Dependents Are:

1. **Spouse** – Individual who is not legally separated, who is of the opposite sex of the Enrolled Member and who is legally married or who submits satisfactory evidence to the Administrator of common law marriage to the Employee or Retiree entered into prior to January 1, 1997 and is not legally separated.
2. **Dependent Child** – An eligible Dependent child of an Enrolled Member must meet one of the following definitions:
   - **Natural child** – A natural child for whom the natural guardian has not relinquished all guardianship rights through a judicial decree. Eligibility begins at birth and ends at the end of the month in which the child reaches age twenty-six (26).
   - **Adopted child** – Eligibility begins on the date of legal placement for adoption and ends at the end of the month in which the child reaches age twenty-six (26).
   - **Stepchild** – Eligibility begins on the date of marriage to the natural parent. Eligibility ends at the end of the month in which the child reaches age twenty-six (26), or at the end of the month in which the stepchild loses his or her status as stepchild of the Enrolled Member, whichever is earlier.
   - **Guardianship** – A child for whom the Enrolled Member is the legal guardian. Eligibility begins on the date the legal guardianship is established. Eligibility ends at the end of the month in which the child reaches age twenty-six (26), or at the end of the month in which the legal guardianship terminates, whichever is earlier. Certification documentation requirements are at the discretion of the Administrator. However, a judicial decree from a court of competent jurisdiction is required unless the Administrator concludes that documentation is satisfactory to establish legal guardianship and that other legal papers present undue hardship on the Member or living natural parent(s).
   - **Totally Disabled Child** – A natural child, legally adopted child or stepchild age twenty-six (26) or older, if the child was physically or mentally disabled before age twenty-six (26), continues to be physically or mentally disabled, lives with the Enrolled Member or is institutionalized, and depends primarily on the Enrolled Member for support and maintenance.

DOCUMENTATION CONFIRMING ELIGIBILITY FOR YOUR SPOUSE OR DEPENDENTS

SHBP requires documentation concerning eligibility of dependents covered under the plan. **No health claims will be paid until the documentation is received and approved by SHBP. Please write your Social Security Number on each document. Do not send originals as they will not be returned. Please give the documentation to your employer.**

- **Spouse** – Certified copy of marriage license or copy of your most recent Federal Tax Return (filed jointly with spouse)including legible signatures for you and your spouse with financial information blacked out. The spouse's Social Security Number is also required.
- **Natural or adopted child –** Certified copy of birth certificate or birth card issued by hospital which lists parents by name are accepted for new births and certified copy of court documents establishing adoption and stating date of adoption, or, if adoption is not finalized, certified or notarized legal documents establishing the date of placement for adoption. If a certified copy of the birth certificate is not available for an adopted child, other proof of the child's date of birth is required. The Social Security Number is required for all children two and older.
- **Stepchild** – Certified copy of birth certificate showing your spouse is the natural parent of the child AND certified copy of marriage license showing the natural parent of the child is your spouse or a copy of your most recent Federal Tax Return (filed jointly with spouse) including legible signatures for you and your spouse with financial information blacked out. The Social Security Number is required for all children age two and older.
- **Legal Guardianship** – Certified copy of court documents establishing the legal guardianship and stating the dates on which the guardianship begins and ends and a certified copy of the birth certificate or other proof of the child's date of birth. The Social Security Number is required for all children age two and older.

MAKING CHANGES WHEN YOU HAVE A QUALIFYING EVENT

If you experience a qualifying event, you may be able to make changes for yourself and your dependents if you make the request within the required time period of the qualifying event which in most cases is 31 days. In some cases, the time period may be extended to 60 or 90 days based on state and federal law or SHBP regulations. The requested change must correspond to the qualifying event. For a complete description of qualifying events, see your Summary Plan Description available online at www.myshbp.ga.gov. You may also contact the Eligibility Call Center for assistance at 800-610-1863.

Qualifying Events Include, But are Not Limited to:

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

HAVING A BABY

You will need to add your newborn within the first of the month of his or her birth. A newborn's charges will not be covered if the effective date occurs the month after the birth. Since SHBP premiums are paid one month in advance of the coverage, retroactive deductions may apply.

IMPORTANT INFORMATION

- Please submit your change request within the required time period, which is usually 31 days. In some cases the time period may be extended to 60 or 90 days based on state and federal law or SHBP regulations.
- Change requests should not be held waiting on additional information, such as Social Security Number, marriage or birth certificate.
- SHBP will accept dependent verification at anytime during the Plan Year and coverage will be retroactive to the qualifying event date or first of the Plan Year, whichever is later.
- No health claims will be paid until the documentation is received and approved by SHBP.
- The member's Social Security Number MUST be written on each document SHBP receives so we can match your dependents to your record. Do not send originals as they will not be returned.

COBRA RIGHTS – DEPENDENTS

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

ENROLLING IN SHBP COVERAGE

BEFORE YOU ENROLL

You should:

- Read this *Decision Guide* and Summary Plan Description to understand your Health Plan Options prior to making your health election.
- Read and understand the SHBP Tobacco and Spousal Surcharge Policies on pages 8 and 9, and answer all questions regarding these surcharges. If you fail to answer the questions, the surcharge(s) will apply for the 2012 Plan Year unless you experience a qualifying event or you complete the applicable steps to remove the surcharges as outlined on page 9.
- Gather eligibility verification documents for all dependents for whom coverage has been requested to submit within the required time frame.
- Understand the election you make will be valid for the 2012 Plan Year unless you experience a qualifying event.
- Additional options may be available to you during the Fall Open Enrollment for coverage effective January 1, 2013.

HEALTH BENEFIT COST ESTIMATORS

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

You can use the PCE to review cost information for prescriptions, anticipated tests and procedures.

HOW TO ENROLL

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

- As a new hire, within 31 days of your hire date. If you join the SHBP during that first 31-day enrollment opportunity, your coverage will go into effect on the first day of the month after you complete one full calendar month of employment. See your personnel/payroll office for instructions on how to enroll or if you have benefit questions, you may call the vendor directly at the telephone numbers listed on the inside of the front cover of the Decision Guide.
- If you decline coverage under SHBP when you first become eligible and later decide to enroll due to a qualifying event or at a future Open Enrollment period, your options will be limited to the HRA, HDHP and TRICARE supplement for your first Plan year of coverage.
- As a result of a qualifying event. *See Making Changes When You Have a Qualifying Event, page 5 of this guide for more details.*
- If you terminate employment and are re-hired by any employer eligible for the SHBP during the same Plan year, you must enroll in the same Plan option and tier (even if there is a gap in coverage) provided you are eligible for that option and have not had a qualifying event since coverage ended.
- If the termination is in one year and you are hired in the following year with a gap in coverage, you are restricted to the consumer driven health plan options: the Health Reimbursement Arrangement (HRA), High Deductible Health Plan (HDHP) and TRICARE Supplement with the new employer.

IF YOU DECIDE TO BECOME A SHBP MEMBER, YOU WILL HAVE TWO MAJOR CHOICES TO MAKE:

1. Your coverage options:

CIGNA Healthcare

- Standard Health Reimbursement Arrangement (HRA)
- Standard High Deductible Health Plan (HDHP)*

UnitedHealthcare

- Standard Health Reimbursement Arrangement (HRA)
- Standard High Deductible Health Plan (HDHP)*

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

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

- SHBP is required to obtain the Social Security Number of each covered dependent.

3. Which coverage tier? Select the coverage tier you desire for the dependents that you choose to cover. You will be locked into the tier for the 2012 Plan Year unless you experience a qualifying event.

- You
- You+ Child(ren)
- You + Spouse
- You + Family*

**You+ Family = You + Spouse + Child(ren)*

***NOTE:** Additional options may be available to you during the Fall Open Enrollment period for the following plan year.*

WHAT HAPPENS IF I HAVE OTHER INSURANCE?

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

When you have other group or Medicare coverage and SHBP coverage, the benefit under SHBP will be no greater than it would have been if there was no coverage other than that of SHBP. Non-covered services or items, penalties and amounts balance billed are not part of the allowed amount and are the member's responsibility.

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

WHAT IF I AM WORKING AND AM ELIGIBLE FOR MEDICARE?

Federal Law requires SHBP to pay primary benefits for active employees and their dependents. Active members or their covered dependents may choose to delay Medicare enrollment. Termination of active employment is a qualifying event for enrolling in Medicare without penalty if your plan is creditable. Remember the HDHP plan is NOT creditable. To avoid the penalty, you should enroll in a creditable plan at Open Enrollment if someone under your coverage will turn 65 during the plan year and they will not be enrolling in Medicare due to your active employment.

IMPORTANT NOTE

- Dual coverage (more commonly referred to as State on State coverage) is when two members are eligible for coverage both as an employee and spouse under SHBP. For example: a member is eligible for SHBP coverage through his/her employment and his/her spouse is also eligible for SHBP coverage as an employee.
- If both members are eligible for coverage as employees, it may not be cost effective to cover each other as dependents. This is because regardless of the other coverage (SHBP or another group policy) you will still be responsible for co-payments, deductibles and non-covered or ineligible charges.

SURCHARGE POLICY

You should be aware that SHBP charges a Tobacco and Spousal Surcharge. A $80 Tobacco Surcharge will be added to your monthly premium if you or any of your covered dependents have used tobacco products in the previous 12 months. SHBP provides limited coverage of tobacco cessation medications. To find out how to qualify for coverage of these medications, contact your health care vendor (CIGNA or UHC) for details.

A $50 Spousal Surcharge will be added to your monthly premium if you have elected to cover your spouse and your spouse is eligible for coverage through his/her employment but chose not to take it. If your spouse is eligible for coverage with SHBP through his/her employment, the spousal surcharge will be waived.

You will automatically be charged the applicable surcharges if you fail to answer all questions concerning the surcharges. The surcharges will apply to your premium until the next Plan Year unless you take steps to have the surcharges removed. See next page for details.

SPOUSAL SURCHARGE VERIFICATION

SHBP will be requesting from you documentation or an affidavit from your spouse's employer verifying the spouse is not eligible for health insurance. Therefore, it is important that you answer the Spousal Surcharge questions accurately to avoid disruption of coverage. You do not need to take any additional action until documentation is requested.

HOW TO REMOVE SURCHARGES

Tobacco

You may have the Tobacco Surcharge removed if you contact your health care vendor and follow their instructions. See the inside cover for vendor contact information.

Spousal

SHBP charges a Spousal Surcharge for SHBP members who cover their spouses when the spouse declines health coverage through their employer. You may have the Spousal Surcharge removed:

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

No refund in premiums will be made for previous health deductions that included the surcharge amounts. Additional information is available at www.dch.georgia.gov/shbp.

WHO SHOULD I CONTACT IF I HAVE QUESTIONS?

Benefit Questions:

- CIGNA for HRA or HDHP Options – 800-633-8519
- UHC HRA – 800-396-6515
- UHC HDHP – 877-246-4189

Eligibility Questions:

- SHBP Call Center – 800-610-1863
- SHBP E-Mail – shbpnoreply@dch.ga.gov

HOW DO I DECIDE WHICH PLAN IS BEST FOR ME?

This can be a difficult decision but listed below are some things you may want to consider when making your decision.

- Under the HRA Plan, SHBP contributes dollars for your first dollar coverage for eligible health care and pharmacy expenses.
- Your prescription drug costs apply to the deductible and out-of-pocket maximum under the HDHP Option.
- If you take a number of prescriptions, compare costs for your prescriptions under each plan and you may want to consider using the Mail Order Program which may lower your prescription drug costs.

IMPORTANT INFORMATION

If you change options or vendors during the year, any amounts applied toward your deductible or out-of-pocket are not transferred to the new option.

UNDERSTANDING YOUR PLAN OPTIONS

Below you will find a brief description of each option offered. CIGNA and UnitedHealthcare are your healthcare vendors and each offer an HRA and HDHP option.

NOTE: If you are enrolling in coverage for the first time or if you were not covered by SHBP in 2011, your options are the Standard HRA, Standard HDHP and TRICARE Supplement for your first Plan Year. During the next Open Enrollment Period, you may have additional options for the next Plan Year.

Each plan provides a statewide and national network of providers across the United States. None of the Plan Options require the selection of a primary care physician (PCP) or referrals to a specialist. In addition, there are no lifetime maximums and all preventive care benefits are covered at 100% at no cost to you when you use in-network providers only.

STANDARD HEALTH REIMBURSEMENT ARRANGEMENT (HRA)

The HRA is a Consumer-Driven Health Plan Option (CDHP) that includes a SHBP funded health reimbursement account that provides first dollar coverage for eligible health care and pharmacy expenses. The amount funded by SHBP into your HRA reduces your deductible and out-of-pocket maximum for covered medical expenses. These dollars offset some of your initial upfront costs. **Pharmacy claims are not applied to the deductible or out-of-pocket maximum including any amounts paid out of your HRA fund for pharmacy expenses.**

Prescription drugs have a three (3) tier structure with a minimum and maximum co-insurance amount you will pay. You may use your HRA credits to pay for your pharmacy co-insurance amounts but any monies credited for pharmacy expenses will not be used to satisfy your deductible and out-of-pocket maximum. In other words, only your medical expenses will count toward your deductible and out-of-pocket max. Once all your HRA credits have been exhausted, you will to pay your co-insurance minimum or maximum based on the tier for your prescription drugs and will not have to satisfy your deductible.

IMPORTANT INFORMATION

UnitedHealthcare members will need to present their Pharmacy Health Care Spending Card (PHCSC) for prescription drugs only and medical ID card to access their HRA credits. Once your information is on file with your pharmacy, you only need to present your PHCSC card to use HRA dollars to pay for your covered medications. The PHCSC must be activated one business day before presenting it at the pharmacy. No separate card is required for CIGNA.

Any unused dollars in your HRA roll over to the next Plan Year if you are still participating in this Option, but will be forfeited if you change options during the OE or due to a qualifying event.

If you have a flexible spending account, HRA dollars must be used first before using dollars from your flex account.

STANDARD HIGH DEDUCTIBLE HEALTH PLAN (HDHP)

The HDHP Option offers in-network and out-of-network benefits and provides access to a network of providers on a statewide and national basis across the United States. This Plan has a low monthly premium but you must satisfy a separate in-network and out-of-network deductible and out-of-pocket maximum. The deductible applies to all health care expenses including pharmacy before benefits are paid. Preventive care is covered at 100% when seeing an in-network provider and you do not have to satisfy the deductible. **If you cover dependents, you must meet the ENTIRE deductible before benefits are payable for any covered member. You pay co-insurance after you have satisfied the deductible rather than set dollar co-payments for medical expenses and prescription drugs until the out-of-pocket maximum is met.** Also, you may qualify to start a Health Savings Account (HSA) to set aside tax-free dollars to pay for eligible health care expenses now or in the future. HSAs typically earn interest and may even offer investment options. See the Benefits Comparison chart that starts on page 15 to compare benefits under the HDHP to other Plan Options. Go to www.irs.gov/publications/p969 for more information.

IMPORTANT INFORMATION

Prescription drug coverage under the HDHP Plan is not creditable. That means if you are enrolled in the HDHP Plan at the time you or your spouse turn 65 and don't sign up for Medicare Part D Plan or a SHBP Medicare Advantage Plan, even if you or your spouse are still actively working, you may be charged a late enrollment penalty. See the legal notice for more information.

HEALTH SAVINGS ACCOUNT (HSA) – INFORMATION ONLY

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

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

- You can contribute up to $3,100 single, $6,250 family as long as you are enrolled in the HDHP. These limits are set by federal law. Unused money in your account carries forward to the next Plan year and earns interest.
- HSA dollars can be used for eligible health care expenses even if you are no longer enrolled in the HDHP or any SHBP coverage.
- HSA dollars can be used to pay for health care expenses (medical, dental, vision, and over-the-counter medications when a doctor states they are medically necessary) that the IRS considers tax-deductible that are NOT covered by any health plan (see IRS Publication 502 at www.irs.gov).
- You can contribute an additional $1,000 if you are 55 or older (see IRS Publication 969 at www.irs.gov).

TRICARE SUPPLEMENT FOR ELIGIBLE MILITARY MEMBERS

The TRICARE Supplement Plan is an alternative to SHBP coverage that will be offered to employees and dependents who are eligible for SHBP coverage and are also eligible for TRICARE. The TRICARE Supplement Plan is not sponsored by the SHBP, the Department of Community Health or any employer. The TRICARE Supplement Plan is sponsored by the American Military Retirees Association and is administered by the Association & Society Insurance Corporation. In general, to be eligible, the employee and dependents must each be under age 65, ineligible for Medicare and registered in the Defense Enrollment Eligibility Reporting System (DEERS). For complete information about eligibility and benefits, contact 866-637-9911 or visit www.asicorporation.com. You may also find information at www.myshbp.ga.gov.

The TRICARE Supplement Plan works with TRICARE to pay the balance of covered medical expenses after TRICARE pays. The TRICARE Supplement Plan helps to pay 100% of members' TRICARE outpatient deductible, cost share, co-payments plus 100% of covered excess charges. Members have flexibility and freedom of choice in selecting civilian providers (physicians, specialists, hospitals and pharmacies).

Points to Consider if You Elect TRICARE Supplement Plan Coverage

- TRICARE will become your primary coverage.
- TRICARE Supplement Plan will become the secondary coverage.
- The eligibility rules and benefits described in the TRICARE Supplement Plan will apply.
- TRICARE covers unmarried dependent children under the age of 21 or 23 if a full-time student.
- Unmarried adult children under the age of 26 who are no longer eligible for regular TRICARE must be enrolled in TYA through TRICARE before enrolling in the TRICARE Supplement Plan offered by SHBP.
- Tobacco and Spousal Surcharges will not apply.
- COBRA rights will not apply.
- If you or your dependents lose eligibility for SHBP coverage while you are enrolled in the TRICARE Supplement Plan, you will be offered a portability feature by the Association & Society Insurance Corporation (ASI), administrator of TRICARE Supplement.
- Loss of eligibility for the TRICARE Supplement Plan is a qualifying event. If you continue to be eligible for coverage under the SHBP, you may enroll in an SHBP Option outside of the Open Enrollment period if you make a request within 31 days of losing eligibility for the TRICARE Supplement Plan.
- Attainment of age 65 and eligibility for Medicare causes a loss of eligibility for TRICARE Supplement Plan coverage. This is a qualifying event and you must make a request within 31 days in order to re-enroll in an SHBP coverage option.

IMPORTANT INFORMATION

- Neither SHBP or ASI can verify eligibility for TRICARE or register you or your dependents in DEERS. Only the employee, spouse or dependent child age 18 or older can verify eligibility and register in DEERS. To verify eligibility and register in DEERS, contact DEERS at 800-538-9552
- Employers are prohibited by law from paying any portion of the cost of TRICARE Supplement Coverage

Questions about eligibility or benefits should be addressed to ASI at www.asicorporation.com or call 866-637-9911.

PEACHCARE FOR KIDS®

If you are eligible for SHBP coverage you may enroll your children in the PeachCare for Kids® Program if they meet PeachCare requirements. Program information is available at www.peachcare.org. PeachCare provides the same coverage as private programs - including check-ups, prescription medicine, dental and vision care. Some additional benefits of PeachCare are low premiums and no deductibles. Currently, the monthly premium for PeachCare coverage is $10 to $35 for one child and a maximum of $70 for two or more children living in the same household, depending on household income.

The PeachCare for Kids website has an income calculator available to help you determine if your children are potentially eligible for this program. If you enroll your children, and they are accepted into the program, you have 60 days to notify SHBP of the enrollment so SHBP can remove the children from SHBP coverage and change your premiums (if your tier will change). Children cannot be covered under both SHBP and PeachCare.

If you child loses PeachCare coverage in the future, you have 60 days from the date of the loss of PeachCare coverage to enroll your children in SHBP. It is not considered a qualifying event to enroll your children in SHBP coverage if PeachCare denies enrollment. Therefore, you should not discontinue coverage for your child until you receive confirmation that PeachCare has approved their enrollment.

Please contact PeachCare for Kids® directly regarding any questions about this program. The website address is www.peachcare.org; phone 1-877-427-3224/ 1-877-GA PEACH.

COMPARISON OF THE MOST COMMON BENEFITS UNDER SHBP AND EACH PEACHCARE PROGRAM – CO-PAYS, DEDUCTIBLES UNDER EACH PLAN

	SHBP Plans	PeachCare
Deductible	Minimum of $1,300 to maximum of $7,000	No Deductible, No co-pays
Emergency Room	Minimum of 10% or $150 copay	No Deductible, No co-pays
Hospital Services (inpatient/outpatient)	Minimum of 15% or 40% after satisfying the deductible	No Deductible, No co-pays
Physician Office Services (illness/injury)	Minimum of 15% after satisfying the deductible or $35 - $55 copay 85%/60%	No Deductible, No co-pays
Mental Health/Substance Abuse (inpatient). Prior notification required. Visits unlimited	You will pay a minimum of 10% to 20% in-network and 40% if going out-of-network.	No Deductible, No co-pays
Pharmacy - (Up to a 31 day supply)	Minimum of $10 with maximum of $125	No Deductible, No co-pays
Dental Coverage - Repair of sound natural teeth or tissue when damaged by traumatic injury.	Treatment covered only for repair of natural teeth due to a traumatic injury. You will pay at least 5% or $45-$55 after satisfying the deductible.	No Deductible, No co-pays
Vision Benefits	100% coverage for routine eye exam every 2 years.	No Deductible, No co-pays
Oral Maxillofacial Surgery	No benefit	No Deductible, No co-pays
Note: You will have greater out-of-pocket expenses under SHBP Plans. Consider this when deciding about applying for coverage for your child(dren) under PeachCare for Kids.		

Benefits Comparison: Standard HRA – HDHP

Schedule of Benefits for You and Your Dependents for January 1, 2012 – December 31, 2012

	Standard HRA Option		Standard HDHP Option	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Covered Services				
Deductible/Co-Payments • You • You + Spouse • You + Child(ren) • You + Family	$1,300* $2,250* $2,250* $3,250* **HRA credits will reduce this amount*		$1,750 $3,500 $3,500 $3,500	$3,500 $7,000 $7,000 $7,000
Out-of-Pocket Maximum • You • You + Spouse • You + Child(ren) • You + Family	$3,000* $5,000* $5,000* $7,000* **HRA credits will reduce this amount*		$2,650 $4,600 $4,600 $4,600	$5,800 $10,800 $10,800 $10,800
HRA Credits • You • You + Spouse • You + Child(ren) • You + Family	$375 $650 $650 $1,000		None	
Physicians' Services	*The Plan Pays*		*The Plan Pays*	
Primary Care Physician or Specialist Office or Clinic Visits Treatment of illness or injury	85% coverage; subject to deductible	60% coverage; subject to deductible	80% coverage;subject to deductible	60% coverage; subject to deductible
Primary Care Physician or Specialist Office or Clinic Visits for the Following: • Wellness care/preventive health care • Annual gynecological exams(these services are not subject to the deductible)	100% coverage; not subject to deductible	Not covered	100% coverage; not subject to deductible	Not covered
Maternity Care (prenatal, delivery and postpartum)	85% coverage; subject to deductible	60% coverage; subject to deductible	80% coverage; subject to deductible	60% coverage; subject to deductible
Physician Services Furnished in a Hospital • Visits; surgery in general, including charges by surgeon, anesthesiologist, pathologist and radiologist	85% coverage; subject to deductible	60% coverage; subject to deductible	80% coverage; subject to deductible	60% coverage; subject to deductible

Benefits Comparison: Standard HRA – HDHP

Schedule of Benefits for You and Your Dependents for January 1, 2012 – December 31, 2012

	Standard HRA Option		Standard HDHP Option	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Physicians' Services	*The Plan Pays*		*The Plan Pays*	
Physician Services for Emergency Care	85% coverage; subject to in-network deductible		80% coverage; subject to in-network deductible	
Outpatient Surgery • When billed as office visit	85% coverage; subject to deductible	60% coverage; subject to deductible	80% coverage; subject to deductible	60% coverage; subject to deductible
Outpatient Surgery • When billed as outpatient surgery at a facility	85% coverage; subject to deductible	60% coverage; subject to deductible	80% coverage; subject to deductible	60% coverage; subject to deductible
Allergy Shots and Serum	85% coverage; subject to deductible	60% coverage; subject to deductible	80% coverage; subject to deductible	60% coverage; subject to deductible
Hospital Services	*The Plan Pays*		*The Plan Pays*	
Inpatient Services • Inpatient care, delivery and inpatient short-term acute rehabilitation services	85% coverage; subject to deductible	60% coverage; subject to deductible	80% coverage; subject to deductible	60% coverage; subject to deductible
Inpatient Services • Well-newborn care	85% coverage; subject to deductible	60% coverage; subject to deductible	80% coverage; subject to deductible	60% coverage; subject to deductible
Outpatient Surgery Hospital/facility	85% coverage; subject to deductible	60% coverage; subject to deductible	80% coverage; subject to deductible	60% coverage; subject to deductible
Emergency Care—Hospital • Treatment of an emergency medical condition or injury	85% coverage; subject to deductible		80% coverage; subject to in-network deductible	
Outpatient Testing, Lab, etc.	*The Plan Pays*		*The Plan Pays*	
Non Routine laboratory; X-Rays; Diagnostic Tests; Injections—including medications covered under medical benefits—for the treatment of an illness or injury	85% coverage; subject to deductible	60% coverage; subject to deductible	80% coverage; subject to deductible	60% coverage; subject to deductible

Benefits Comparison: Standard HRA – HDHP

Schedule of Benefits for You and Your Dependents for January 1, 2012 – December 31, 2012

	Standard HRA Option		Standard HDHP Option	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Behavioral Health	*The Plan Pays*		*The Plan Pays*	
Mental Health and Substance Abuse Inpatient Facility and Partial Day Hospitalization NOTE: Contact vendor regarding prior authorization	85% coverage; subject to deductible	60% coverage; subject to deductible	80% coverage; subject to deductible	60% coverage; subject to deductible
Mental Health and Substance Abuse Outpatient Visits and Intensive Outpatient NOTE: Contact vendor regarding prior authorization	85% coverage; subject to deductible	60% coverage; subject to deductible	80% coverage; subject to deductible	60% coverage; subject to deductible
Dental	*The Plan Pays*		*The Plan Pays*	
Dental and Oral Care NOTE: Coverage for most procedures for the prompt repair of sound natural teeth or tissue for the correction of damage caused by traumatic injury	85% coverage; subject to deductible	60% coverage; subject to deductible	80% coverage; subject to deductible	60% coverage; subject to deductible
	NOTE: Notification required for all UHC options.			
Temporomandibular Joint Syndrome (TMJ) NOTE: Coverage for diagnostic testing and non-surgical treatment up to $1,100 per person lifetime maximum benefit.	85% coverage; subject to deductible	60% coverage; subject to deductible	80% coverage; subject to deductible	60% coverage; subject to deductible
Vision	*The Plan Pays*		*The Plan Pays*	
Routine Eye Exam NOTE: Limited to one eye exam every 24 months	100% coverage; not subject to deductible	Eye exam not covered	100% coverage; not subject to deductible	Eye exam not covered
Other Coverage	*The Plan Pays*		*The Plan Pays*	
Hearing Services Routine hearing exam	85% coverage for routine exam and fitting; subject to deductible. $1,500 hearing aid allowance every 5 years; not subject to the deductible		80% coverage for routine exam and fitting; subject to deductible. $1,500 hearing aid allowance every 5 years; subject to the deductible	
Ambulance Services for Emergency Care NOTE: "Land or air ambulance" to nearest facility to treat the condition	85% coverage; subject to deductible		80% coverage; subject to in-network deductible	
Urgent Care Services NOTE: All subject to deductible	85% coverage; subject to deductible	60% coverage; subject to deductible	80% coverage; subject to deductible	60% coverage; subject to deductible

Benefits Comparison: Standard HRA – HDHP

Schedule of Benefits for You and Your Dependents for January 1, 2012 – December 31, 2012

	Standard HRA Option		Standard HDHP Option	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Other Coverage	*The Plan Pays*		*The Plan Pays*	
Home Health Care Services NOTE: Prior approval required	85% coverage; subject to deductible	60% coverage; subject to deductible	80% coverage; subject to deductible	60% coverage; subject to deductible
Skilled Nursing Facility Services NOTE: Prior approval required	85% coverage; up to 120 days per Plan year; subject to deductible	Not covered	80% coverage up to 120 days per Plan Year; subject to deductible	Not covered
Hospice Care NOTE: Prior approval required	85% coverage; subject to deductible	60% coverage; subject to deductible	80% coverage; subject to deductible	60% coverage; subject to deductible
Durable Medical Equipment (DME)—Rental or purchase NOTE: Prior approval required for certain DME	85% coverage; subject to deductible	60% coverage; subject to deductible	80% coverage; subject to deductible	60% coverage; subject to deductible
Outpatient Acute Short-Term Rehabilitation Services • Physical Therapy • Speech Therapy • Occupational Therapy • Other short term rehabilitative services	85% coverage; subject to deductible; up to 40 visits per therapy per Plan year (not to exceed a total of 40 visits combined, including any out-of-network visits)	60% coverage; subject to deductible; up to 40 visits per therapy per Plan year (not to exceed a total of 40 visits combined, including any in-network visits)	80% coverage up to 40 visits per therapy per Plan year; subject to deductible (not to exceed a total of 40 visits combined, including any out-of-network visits)	60% coverage up to 40 visits per therapy per Plan year; subject to deductible (not to exceed a total of 40 visits combined, including any in-network visits)
Chiropractic Care NOTE: UHC Coverage up to a maximum of 20 visits; CIGNA – up to a maximum of 20 days, per plan year	85% coverage; subject to deductible	60% coverage; subject to deductible	80% coverage; subject to deductible	60% coverage; subject to deductible
Foot Care NOTE: Covered only for neurological or vascular diseases	85% coverage; subject to deductible	60% coverage; subject to deductible	80% coverage; subject to deductible	60% coverage; subject to deductible
Transplant Services NOTE: Prior approval required	Contact vendor for coverage details			
Pharmacy - You Pay				
Tier 1 Co-payment	15% ($20 min/$50 max) not subject to deductible	40% coverage; not subject to deductible*	20% coverage; subject to deductible $10 min/$100 max	Not covered
Tier 2 Co-payment Preferred Brand	25% ($50 min/$80 max) not subject to deductible	40% coverage; not subject to deductible*	20% coverage; subject to deductible $10 min/$100 max	Not covered
Tier 3 Co-payment Non-Preferred Brand	25% ($80 min/$125 max) not subject to deductible	40% coverage; not subject to deductible*	20% coverage; subject to deductible $10 min/$100 max	Not covered
90-Day Voluntary Mail Order	Tier 1–15% ($50 min/$125 max) Tier 2–25% ($125 min/$200 max) Tier 3–25% ($200 min/$312.50 max) Does not apply to deductible or out-of-pocket max		20% ($25 min/$250 max) No non-network coverage	

LEGAL NOTICES

This section includes Legal Notices that outline your rights under the Women's Health and Cancer Rights Act, Newborns' and Mothers' Health Protection Act, Health Insurance Portability and Accountability Act, the Department of Community Health's use of your protected health insurance and Notice about the early Retiree Reinsurance Program.

Also the information below and on pages 20-23 provide you information about your prescription drug coverage.

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

Your SHBP Option	What happens if you buy an individual Medicare Part D Plan
SHBP Medicare Advantage PPO Standard or SHBP Medicare Advantage PPO Premium Plan	Your MA coverage under SHBP will be terminated and we will move you to the Standard Option and vendor you had before MA PPO and you will pay 100% of the premium.
HRA	Your Medicare Part D Plan will be primary for your prescription drugs unless you are in the deductible or doughnut hole and then SHBP will provide benefits. If you reach the out-of-pocket Limit, SHBP will coordinate benefits with your Medicare Part D Plan. You will not pay a Medicare "late enrollment" penalty
HDHP (High Deductible)	You will have to pay a Medicare "late enrollment" penalty if you miss the initial enrollment period because the HDHP option is not considered "creditable coverage"

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

SHBP
State Health Benefit Plan

IMPORTANT NOTICE FROM THE SHBP ABOUT YOUR CREDITABLE PRESCRIPTION DRUG COVERAGE UNDER ANY OF THE FOLLOWING OPTIONS AND MEDICARE:

CIGNA STANDARD HRA , CIGNA STANDARD HMO AND UNITEDHEALTHCARE STANDARD HRA AND UNITEDHEALTHCARE STANDARD HMO

For Plan Year: January 1 – December 31, 2012

This notice only applies if you are covered under the CIGNA Standard or Wellness HMO or HRA or the UnitedHealthcare Standard or Wellness HMO or HRA.

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

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

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

2 The SHBP has determined that the prescription drug coverage offered by CIGNA Standard HMO, CIGNA Standard HRA, CIGNA Wellness HMO, CIGNA Wellness HRA, UnitedHealthcare Standard HMO, UnitedHealthcare Standard HRA, UnitedHealthcare Wellness HMO and UnitedHealthcare Wellness HRA is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can you Join a Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th. However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current SHBP coverage will be affected. If you join a Medicare drug plan and do not terminate your SHBP coverage, SHBP will coordinate with Medicare drug plan coverage the month following receipt of notice. You should send a copy of your Medicare cards to SHBP at P.O. Box 1990, Atlanta, GA 30301.

Important: If you are a retiree and terminate your SHBP coverage, you will not be able to rejoin the SHBP in the future.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?
You should also know that if you drop or lose your current coverage with SHBP and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

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

For More Information About This Notice Or Your Current Prescription Drug Coverage…
Contact the SHBP Eligibility Unit at (404) 656-6322 or (800) 610-1863. NOTE: You will receive this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage, through SHBP changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage…
More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

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

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

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

Date: October 1, 2011
Name of Entity/Sender: State Health Benefit Plan
Contact–Position/Office: Call Center
Address: 2 Peachtree Street, Atlanta, GA 30334
Phone Number: (800) 610-1863

SHBP
State Health Benefit Plan

IMPORTANT NOTICE FROM THE SHBP ABOUT YOUR NON-CREDITABLE PRESCRIPTION DRUG COVERAGE UNDER ANY OF THE FOLLOWING OPTIONS AND MEDICARE:

CIGNA STANDARD HDHP AND UNITEDHEALTHCARE STANDARD HDHP

For Plan Year: January 1 – December 31, 2012

This notice only applies if you are covered under the CIGNA Standard or Wellness HDHP or the UnitedHealthcare Standard or Wellness HDHP.

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

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

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

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

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

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th.

However, if you decide to drop your current coverage with the SHBP, since it is employer sponsored group coverage, you will be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan; however you also may pay a higher premium (a penalty) because you did not have creditable coverage under SHBP.

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

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?
If you decide to join a Medicare drug plan, your current HDHP coverage under SHBP will be affected. If you enroll in Medicare Part D when you become eligible for Medicare Part D and do not terminate your HDHP coverage, you can keep your HDHP coverage and the HDHP will coordinate benefits with the Part D coverage. SHBP will coordinate with Part D coverage the month following receipt of notice. You should send a copy of your Medicare cards to SHBP at P.O. Box 1990, Atlanta, GA 30301.

Important: If you are a retiree and terminate your SHBP coverage, you will not be able to rejoin the SHBP in the future.

For More Information About This Notice Or Your Current Prescription Drug Coverage...
Contact the SHBP Eligibility Unit at (404) 656-6322 or (800) 610-1863. NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan and if this coverage through SHBP changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage...
More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans. For more information about Medicare prescription drug coverage:

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

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

Date: October 1, 2011
Name of Entity/Sender: State Health Benefit Plan
Contact–Position/Office: Call Center
Address: 2 Peachtree Street, Atlanta, GA 30334
Phone Number: (800) 610-1863

SHBP
State Health Benefit Plan

This notice was prepared by the United States Department of Health and Human Services. By law, the Department of Community Health is required to provide you this notice.

NOTICE ABOUT THE EARLY RETIREE REINSURANCE PROGRAM

September 25, 2011

You are a plan participant, or are being offered the opportunity to enroll as a plan participant, in an employment-based health plan that is certified for participation in the Early Retiree Reinsurance Program. The Early Retiree Reinsurance Program is a Federal program that was established under the Affordable Care Act. Under the Early Retiree Reinsurance Program, the Federal government reimburses a plan sponsor of an employment-based health plan for some of the costs of health care benefits paid on behalf of, or by, early retirees and certain family members of early retirees participating in the employment-based plan. By law, the program expires on January 1, 2014.

Under the Early Retiree Reinsurance Program, your plan sponsor may choose to use any reimbursements it receives from this program to reduce or offset increases in plan participants' premium contributions, co-payments, deductibles, co-insurance, or other out-of-pocket costs. If the plan sponsor chooses to use the Early Retiree Reinsurance Program reimbursements in this way, you, as a plan participant, may experience changes that may be advantageous to you, in your health plan coverage terms and conditions, for so long as the reimbursements under this program are available and this plan sponsor chooses to use the reimbursements for this purpose. A plan sponsor may also use the Early Retiree Reinsurance Program reimbursements to reduce or offset increases in its own costs for maintaining your health benefits coverage, which may increase the likelihood that it will continue to offer health benefits coverage to its retirees and employees and their families.

If you have received this notice by email, you are responsible for providing a copy of this notice to your family members who are participants in this plan.

SHBP
State Health Benefit Plan

STATE HEALTH BENEFIT PLAN ANNUAL LEGAL NOTICES

Women's Health and Cancer Rights Act

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

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

Note: Reconstructive surgery requires prior approval, and all inpatient admissions require prior notification. For more detailed information on the mastectomy-related benefits available under the Plan, you can contact the Member Services unit for your coverage option. Telephone numbers are on the inside front cover of the Decision Guide.

Newborns' and Mothers' Health Protection Act

The Plan complies with the Newborns' and Mothers' Health Protection Act of 1996.
Group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Health Insurance Portability and Accountability Act

The Plan complies with the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). The HIPAA Privacy Notice is attached as Exhibit A. The Notice of Exemption Letter is attached as Exhibit B.

Exhibit A

Revised March 23, 2010.

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. Questions? Call 404-656-6322 (Atlanta) or 800-610-1863 (outside of Atlanta).

The DCH and the State Health Benefit Plan Are Committed to Your Privacy. The Georgia Department of Community Health (DCH) sponsors and runs the State Health Benefit Plan (the Plan). We understand that your information is personal and private. Some DCH employees and companies hired by DCH collect your information to run the Plan. The information is called "Protected Health Information" or "PHI." This notice tells how your PHI is used and shared. We follow the information privacy rules of the Health Insurance Portability and Accountability Act of 1996, ("HIPAA").

Only Summary Information is Used When Developing and Changing the Plan. The Board of Community Health and the Commissioner of the DCH make decisions about the Plan. When making decisions, they review reports that explain costs, problems, and needs of the Plan. These reports never include information that identifies any person. If your employer is allowed to leave the Plan, your employer may also get summary reports.

Plan Enrollment Information and Claims Information is Used in Order to Run the Plan. PHI includes two kinds of information. "Enrollment Information" includes 1) your name, address, and Social Security number; 2) your enrollment choices; 3) how much you have paid in premiums; and 4) other insurance you may have. This Enrollment Information is the only kind of PHI your employer is allowed to see. "Claims Information" includes information your health care providers send to the Plan. For example, it may include bills, diagnoses, statements, X-rays or lab test results. It also includes information you send to the Plan. For example, it may include your health questionnaires, enrollment forms, leave forms, letters and recorded telephone calls. Lastly, it includes information about you that is created by the Plan. For example, it includes payment statements and checks to your health care providers.

Your PHI is Protected by Law. Employees of the DCH and employees of outside companies hired by DCH to run the Plan are "Plan Representatives." They must protect your PHI. They may only use it as allowed by HIPAA.

The DCH Must Make Sure the Plan Complies with HIPAA. As Plan sponsor, the DCH must make sure the Plan complies with HIPAA. We must give you this notice. We must follow its terms. We must update it as needed. The DCH is the employer of some Plan Members. The DCH must name the DCH employees who are Plan Representatives. No DCH employee is ever allowed to use PHI for employment decisions.

Plan Representatives Regularly Use and Share your PHI in Order to Pay Claims and Run the Plan. Plan Representatives use and share your PHI for payment purposes and to run the Plan. For example, they make sure you are allowed to be in the Plan. They decide how much the Plan should pay your health care provider. They also use PHI to help set premiums for the Plan and manage costs, but they are never allowed to use genetic information for these purposes. Some Plan Representatives work for outside companies. By law, these companies must protect your PHI. They also must sign "Business Associate" agreements with the Plan. Here are some examples of what they do:

Claims Administrators: Process all medical and drug claims; communicate with Members and their health care providers; and give extra (assistance) to Members with some health conditions.

Data Analysis, Actuarial Companies: Keep health information in computer systems, study it, and create reports from it.

Attorney General's Office, Auditing Companies, Outside Law Firms: Provide legal and auditing help to the Plan.

Information Technology Companies: Help improve and check on the DCH information systems used to run the Plan.

Some Plan Representatives work for the DCH. By law, all employees of the DCH must protect PHI. They also must get special privacy training. They only use the information they need to do their work. Plan Representatives in the SHBP Division work full-time running the Plan. They use and share PHI with each other and with Business Associates in order to help pay claims and run the Plan. In general, they can see your Enrollment Information and the information you give the Plan. A few can see Claims Information. DCH employees outside of the SHBP Division do not see Enrollment Information on a daily basis. They may use Claims Information for payment purposes and to run the Plan.

Plan Representatives May Make Special Uses or Disclosures Permitted by Law. HIPAA has a list of special times when the Plan may use or share your PHI without your authorization. At these times, the Plan must keep track of the use or disclosure.

To Comply with a Law, or to Prevent Serious Threats to Health or Safety: The Plan may use or share your PHI in order to comply with a law, or to prevent a serious threat to health and safety.

For Public Health Activities: The Plan may give PHI to government agencies that perform public health activities. For example, the Plan may give PHI to DCH employees in the Department of Public Health who need it to do their jobs.

For Research Purposes: Your PHI may be given to researchers for a research project approved by a review board. The review board must review the research project and its rules to ensure the privacy of your information.

Plan Representatives Share Some Payment Information with the Employee. Except as described in this notice, Plan Representatives are allowed to share your PHI only with you, and with your legal personal representative. However, the Plan may inform the employee family member about whether the Plan paid or denied a claim for another family member.

You May Authorize Other Uses of Your PHI. You may give a written authorization for the Plan to use or share your PHI for a reason not listed in this notice. If you do, you may take away the authorization later by writing to the contact below. The old authorization will not be valid after the date you take it away.

You Have Privacy Rights Related to Plan Enrollment Information and Claims Information that Identifies You. Right to See and Get a Copy your Information, Right to Ask for a Correction: Except for some reasons listed in HIPAA, you have the right to see and get a copy of information used to make decisions about you. If you think it is incorrect or incomplete, you may ask the Plan to correct it.

Right to Ask for a List of Special Uses and Disclosures: You have the right to ask for a list of special uses and disclosures that were made after April 2003.

Right to Ask for a Restriction of Uses and Disclosures, or for Special Communications: You have the right to ask for added restrictions on uses and disclosures. You also may ask the Plan to communicate with you in a special way. Right to a Paper Copy of this Notice, Right to File a Complaint without Getting in Trouble: You have the right to a paper copy of this notice. Please contact the SHBP HIPAA Privacy Unit or print it from www.dch.ga.gov. If you think your privacy rights have been violated, you may file a complaint. You may file the complaint with the Plan and/or the Department of Health and Human Services. You will not get in trouble with the Plan or your employer for filing a complaint.

Addresses for Complaints:

SHBP HIPAA Privacy Unit
P.O. Box 1990
Atlanta, Georgia 30301
404-656-6322 (Atlanta) or 800-610-1863 (outside Atlanta)
U.S. Department of Health & Human Services, Office for Civil Rights
Region IV Atlanta Federal Center 61 Forsyth Street SW, Suite 3B70 Atlanta, GA 30303-8909

Exhibit B

ELECTION TO BE EXEMPT FROM CERTAIN REQUIREMENTS OF HIPAA

August 15, 2011

TO: All Members of the State Health Benefit Plan who are not Enrolled in a Medicare Advantage Option

Under a Federal law known as the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Public Law 104-191, as amended, group health plans must comply with a number of requirements. Under HIPAA, state health plans that are "self-funded" may "opt out" of some of these requirements by making a yearly election to be exempt. Your plan option is self-funded because the Department of Community Health pays all claims directly instead of buying a health insurance policy.

Temporary rules implementing the Mental Health Parity and Addiction Equity Act apply January 1, 2012, unless the Department of Community Health again elects to be exempted from this law's requirements. The temporary rules generated more than 4,000 comments; no final rules addressing these comments have been issued. The Department of Community Health has determined to exempt your State Health Benefit Plan ("SHBP") option from the Mental Health Parity and Addiction Equity Act, and the temporary rules' requirements, for the 2012 calendar year.

> Parity in the application of certain limits to mental health benefits. Group health plans (of employers that employ more than 50 employees) that provide both medical and surgical benefits and mental health or substance use disorder benefits must ensure that financial requirements and treatment limitations applicable to mental health or substance use disorder benefits are no more restrictive than the predominant financial requirements and treatment limitations applicable to substantially all medical and surgical benefits covered by the plan.

The exemption from these federal requirements will be in effect for the plan year starting January 1, 2012, and ending December 31, 2012. The election may be renewed for subsequent plan years.

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


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SHBP
State Health Benefit Plan