SHBP
State Health Benefit Plan

ACTIVE EMPLOYEE DECISION GUIDE 2012

Are you engaged in your health?

OPEN ENROLLMENT PERIOD • OCTOBER 11 – NOVEMBER 10, 2011

www.myshbp.ga.gov

ADDITIONAL HELP/CONTACT INFORMATION

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

Vendor	Member Services	Website
CIGNA HRA, HMO, HDHP hours 24/7	800-633-8519 TDD 800-576-1314	www.mycigna.com/shbp
UnitedHealthcare HRA HMO, 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

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

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:

It is my pleasure as Commissioner of the Department of Community Health (DCH) to welcome you to the 2012 Open Enrollment (OE). The dates for this year's OE will be October 11-November 10, 2011. Active employees will make their election for 2012 at the new website www.myshbp.ga.gov by 4:30 p.m. on November 10, 2011.

Like other states, we in Georgia face a number of fiscal and regulatory challenges that have had an impact on our State Health Benefit Plan. We are committed to finding innovative solutions that address these challenges in a way that keeps premiums down, preserves the fiscal integrity of the plan for the future, promotes the health and wellness of our members and offers SHBP members a choice. You will see that this year we have made a number of changes consistent with this approach.

We are particularly pleased to announce the introduction of new voluntary Wellness Plan Options. These Plan Options offer those members who choose to actively engage in wellness activities a discount on their premiums. Our new Standard Plans do not require our members to engage in wellness activities, but will have higher premiums and out-of-pocket costs than the new Wellness Plan Options.

In addition, we are pleased to offer a TRICARE supplement plan option for those members eligible through their military service.

Please take the time to learn more about these and other plan changes before making your 2012 Plan year election. The Active Employee Decision Guide, along with the other plan materials and tools, are designed to help you choose the plan that is best for you and your family. All of this information is available online at www.myshbp.ga.gov.

All of us at DCH are committed to doing the best job possible to meet the current and future needs of our members. Because your feedback is important to us, we have included a survey after you have made your online 2012 Plan election. Please take the time to complete the survey to help us better serve you.

Sincerely,

David A. Cook
Commissioner

WELCOME TO THE ACTIVE EMPLOYEE OPEN ENROLLMENT PERIOD (OE)

OCTOBER 11 – NOVEMBER 10, 2011

HOURS: 4 a.m. 10/11 – 4:30 p.m. 11/10

FOR PLAN COVERAGE JANUARY 1, 2012 – DECEMBER 31, 2012

This guide will provide you with a brief explanation of each plan option and information about changes that will impact all members. It is very important that you carefully read the Decision Guide before making your election for the 2012 Plan Year. This book, Plan rates and other information can be found at www.dch.georgia.gov/shbp or www.myshbp.ga.gov. To help you navigate the booklet, the guide is divided into sections.

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.

TABLE OF CONTENTS

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.

2012 PLAN CHANGES

ANNOUNCING NEW PLAN OPTIONS

SHBP is excited to announce new Wellness and Standard plan offerings through CIGNA and UnitedHealthcare (UHC). You will be able to select coverage from the following options during OE:

CIGNA Wellness HRA	CIGNA Standard HRA
CIGNA Wellness HDHP	CIGNA Standard HDHP
CIGNA Wellness HMO	CIGNA Standard HMO
UHC Wellness HRA	UHC Standard HRA
UHC Wellness HDHP	UHC Standard HDHP
UHC Wellness HMO	UHC Standard HMO

TRICARE Supplement

The Wellness Options are designed to help you (and your spouse, if covered) become a more active participant in your health and require you to take additional steps in engaging in better health. If you do not wish to participate in the Wellness Options, the Standard Options are available to you. With these new Plan Options, all members will need to make a new election this year. Please go to page 7 for more information.

The new TRICARE Supplement option is available to active and retired military enrolled in TRICARE. Please see page 10 for more information.

NEW WEB PORTAL - www.myshbp.ga.gov

SHBP has a new website for you to make your election during the OE for the 2012 Plan Year and to obtain information about benefits, premiums, etc. Just go to www.myshbp.ga.gov. You can also access this site after OE closes and view the election you made for the 2012 Plan Year. See page 8 for more information.

TOBACCO CESSATION MEDICATION

SHBP will now provide 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. For removal of the Tobacco Surcharge, see the Tobacco Surcharge policy online at www.myshbp.ga.gov.

HRA PRESCRIPTION DRUG BENEFITS

Prescription drugs will change to a three (3) tier structure with a minimum and maximum co-insurance amount paid by the member. You no longer have to satisfy a deductible before pharmacy benefits are paid. In addition, you may continue to use your HRA credits to pay for your new pharmacy co-insurance amounts but any monies credited for pharmacy expenses will no longer be combined with your medical benefits 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 continue to pay only your co-insurance amounts without having to satisfy your deductible and out-of-pocket max. The benefits are the same for the Wellness and Standard Plans.

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 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.

HRA PHARMACY INFORMATION

Coverage Tier	Wellness and Standard HRA Plans
Retail Pharmacy	Tier 1 – 15% ($20 min/$50 max) Tier 2 – 25% ($50 min/$80 max) Tier 3 – 25% ($80 min/$125 max)
90-Day Retail Pharmacy	Tier 1 – 15% ($60 min/$150 max) Tier 2 – 25% ($150 min/$240 max) Tier 3 – 25% ($240 min/$375 max)
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)

PEACHCARE FOR KIDS® ENROLLMENT

Federal law has changed and now allows the PeachCare for Kids program to enroll children of members covered under SHBP. See page 6 for more information.

BARIATRIC SURGERY COVERAGE

Bariatric surgery will no longer be covered under any Plan Option.

VISION HARDWARE/LENS COVERAGE

The $200 Vision hardware/lens benefit will no longer be available under either of the HMO options.

INCREASE IN PREMIUMS

All SHBP members will have an increase in health premiums for 2012. The amount of the increase varies based on the Plan Option selected. Please refer to the rates posted online and on your personalized change form. Rates are also posted on www.myshbp.ga.gov.

SPOUSAL SURCHARGE VERIFICATION

Members covering their spouses are required to pay the Spousal Surcharge if their spouse is eligible for health insurance under their own employer and does not enroll in that coverage. 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.

ELIGIBILITY CHANGES

- SHBP will now allow 90 days from the date of birth to add a newborn. You must have you + child(ren) or family coverage at the time of birth for newborn charges to be covered.
- SHBP will now allow 90 days for the surviving spouse to notify us of the death of the SHBP member to request to continue coverage.

ELECTION ERROR REPORTING

It is important to verify your election, that you received the correct insurance card and the correct amount is deducted from your check. If you discover that a mistake was made, you will need to complete the Open Election Correction Form available online at www.dch.georgia.gov/shbp or by contacting your HR Manager. This form must be completed and given to your HR Manager in time to fax to SHBP by December 31, 2011. You can view your coverage election online at www.myshbp.ga.gov after OE closes and see the amount that will be deducted from your check.

DISEASE MANAGEMENT PHARMACY CO-PAYMENT/CO-INSURANCE WAIVER PROGRAM

This program will only be available for members enrolled in the Wellness HMO and Wellness HRA Plan Options. Contact CIGNA or UnitedHealthcare for details.

NEW WELLNESS PLAN OPTIONS

The Wellness Plan Options are part of a multi-year Wellness Program. Each year, a member electing one of the Wellness Plans promises to take additional steps toward better health than members who enroll in a Standard Plan. Once enrolled in a Wellness Plan, members must complete those additional steps to retain eligibility for a Wellness Plan the following year. Enrollment in a Wellness Plan is voluntary. Members who do not wish to participate in a Wellness Plan may elect one of the Standard Plans and will not be required to take any additional steps.

Year One Wellness Plan Requirements

When you enroll in a Wellness Option, you will complete a Wellness Promise to take the following two actions:

1) You and your spouse (if covered) will complete your Plan's (CIGNA or UnitedHealthcare) online Health Assessment through www.mycigna.com or www.myuhc.com between January 1 – June 30, 2012; and
2) You and your spouse (if covered) will obtain a biometric screening between July 1, 2011 and June 30, 2012. The required screening must include the following four measurements: blood pressure, body mass index (BMI), cholesterol and glucose.

These screenings are considered preventive and are covered at 100%. The Promise applies only to the SHBP member and spouse (if covered).

Screenings may be obtained at your in-network physician's office. Your physician must complete the "physician screening form" and securely fax the form to your health care vendor. The physician screening form will be available on January 1, 2012 at www.mycigna.com, www.myuhc.com and www.myshbp.ga.gov.

If you or your spouse (if covered) do not take the Health Assessment, complete and have your physician submit the results of the required screening that includes all four measurements by the June 30, 2012 deadline, you will not be eligible to enroll in any of the Wellness Plan Options the following year.

Your reward for making the Wellness Promise and enrolling in one of the Wellness Plans is lower premiums and lower out-of-pocket expenses than in the Standard Plans. There are also slight differences between the Wellness and Standard Plan designs that are outlined in the charts on pages 15-22.

Year Two Wellness Plans Requirements

During year two of the program, you and your spouse (if covered) will be required to complete the health assessment and complete the screenings again. In addition to these two requirements, those members whose screening results are not within normal limits for any biometric target, must demonstrate that they are attempting to reach these targets. The requirement is for the member to engage by taking action, regardless of whether the target is actually achieved or not. Members who can not attempt to achieve the targets due to a medical condition must have their doctor submit a form that will be available through their health care vendor. Information regarding the required actions for year two will be available by next year's open enrollment. Requirements may change for the program each year so make sure you carefully read the information about the Wellness program each year.

If you decide not to participate in a Wellness Option in year one, you will have the opportunity to participate in year two, if you wish.

YOUR HEALTH & WELLNESS

After completing your biometric screening you should follow up with your Primary Care Physician (PCP) to discuss your test results and to develop an individual health and wellness plan. If you don't have a PCP, each vendor has an online tool to assist you in finding a physician. Just sign on to the vendor's website and click on the Find a Doctor/Physician link. Developing an ongoing relationship with one physician who knows you and your medical history can lead to better overall outcomes and lower health care costs.

If your biometric results are out-of-range, both vendors have telephonic and online wellness coaching programs and resources available to help you on your road to a healthier you. These programs are free for covered members. The chart at the bottom of the page suggests programs you may want to consider.

What Else 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

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.

STANDARD PLAN OPTIONS

SHBP will also offer HRA, HMO and HDHP Standard Plans. Under these Plans, you will not have to make a promise or take steps to improve your health. The same services will be covered under these Plans but you will have higher premiums, co-payments, deductibles, co-insurance and out-of-pocket maximums.

- HRA Plan – you will not be able to earn the $125 for obtaining your annual physical and taking your online health assessment.
- Disease Management Program Waiver – will not apply to the Standard Plans.
- You should carefully compare the benefits under each plan on page 15-22.

Wellness and Standard Plan Differences

HRA PLAN		
Coverage Tier	Wellness HRA Contribution	Standard HRA Contribution
You	$500	$375
You + Spouse	$1,000	$650
You + Child(ren)	$1,000	$650
You + Family	$1,500	$1,000

HDHP PLAN		
Deductible (In/Out-of-Network)	Wellness HDHP	Standard HDHP
You	$1,500/$3,000	$1,750/$3,500
You + Spouse	$3,000/$6,000	$3,500/$7,000
You + Child(ren)	$3,000/$6,000	$3,500/$7,000
You + Family	$3,000/$6,000	$3,500/$7,000
Out-of-Pocket Maximum (In/Out-of-Network)		
You	$2,400/$5,300	$2,650/$5,800
You + Spouse	$4,100/$9,800	$4,600/$10,800
You + Child(ren)	$4,100/$9,800	$4,600/$10,800
You + Family	$4,100/$9,800	$4,600/$10,800
Co-insurance (In/Out-of-Network)		
Co-insurance	90% / 60%	80% / 60%
Mail Order		
90-Day Mail Order	80% ($25 min/$250 max) No non-network coverage	

HMO PLAN		
Type of Service	Wellness HMO Co-Payment	Standard HMO Co-Payment
Primary Care Physician	$35	$45
Specialist	$45	$55
90-Day Mail Order	Tier 1—$50 Tier 2—$125 Tier 3—$225	

IMPORTANT REMINDERS

SHBP introduced the voluntary mail pharmacy benefit program on July 1, 2011. Please refer to the chart on pages 21-22 for this benefit.

PEACHCARE FOR KIDS®

We are happy to announce that effective January 1, 2012 employees eligible for SHBP coverage may now enroll their 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 will have 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.

MAKING YOUR HEALTH ELECTION FOR 2012

WHO MUST PARTICIPATE IN OPEN ENROLLMENT?

Everyone Should Participate as We Have New Plan Options

You should participate if you:

- Select a new Wellness or Standard Option.
- Plan to change coverage tiers.
- Need to add or disenroll eligible dependents.
- Need to answer surcharge questions.
- Plan to discontinue coverage.
- Need to enroll for health care coverage.
- Plan to retire during the year. Carefully review the "If you are retiring" pages 13-14.

WHAT SHOULD I DO BEFORE MAKING MY ELECTION?

- Evaluate your health care needs and compare the benefits under each option in relation to the premiums by going to www.mycigna.com or www.welcometomyuhc.com/shbp. These sites explain the differences in the plans and have cost estimator tools to help you determine which plan costs are less along with other valuable tools.
- Verify your provider(s) will be participating in the option you choose by going to the vendors' websites or calling the vendors.
- Check the distance you will have to drive to see your provider(s).
- Check the Preferred Drug Lists of each vendor for each option to see if your prescriptions are covered and at what co-payment or co-insurance level.
- If you fail to answer the surcharge questions, surcharges will apply. Steps for removal of surcharges can be found at www.myshbp.ga.gov.

WHO SHOULD I CONTACT IF I HAVE QUESTIONS?

Benefit Questions:

- CIGNA for HRA, HMO or HDHP Options – 800-633-8519
- UHC HRA – 800-396-6515
- UHC HMO, 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.

- Are you able to afford your prescription drugs if you have to satisfy a deductible? If the answer is "No" then you should consider enrolling in the HRA or HMO Option.
- If you have very low or very high medical expenses, you may want to consider enrollment in the HRA or HDHP Plans. The premiums are lower than the HMO and the co-insurance applies to your out-of-pocket limit (except for prescription drugs under the HRA). With high medical expenses, the out-of-pocket limit is reached more quickly and expenses are then paid at 100% after the limit is reached.
- If you have very low expenses, the premium is lower in the HRA and you have 100% coverage for covered services until your HRA dollars are exhausted. Also, if you don't use all of your HRA dollars, they will roll to the next year provided you are in a HRA 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 should 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.

MAKING MY 2012 ELECTION

Online

- Online at www.myshbp.ga.gov; 4 a.m. October 11 – 4:30 p.m. November 10.
- You must register before you can log in to the website.
- If you are unable to access the site, contact SHBP for assistance at 800-610-1863.
- Make sure you select the correct option and tier you wish to have for the 2012 Plan Year.
- Answer the surcharge questions.
- Verify your dependents.
- Verify your home address.
- Remember to click CONFIRM to finalize your election.
- You may go online multiple times; however, the last option selected and confirmed at the close of OE will be your option for 2012 unless you experience a qualifying event that allows you to make a change.
- Remember a confirmation number will be shown once your election has been processed. You should copy this number or print the confirmation page and keep it.
- Your election must be confirmed by the end of the OE at 4:30 p.m. on November 10, 2011.
- Do not wait until the last minute to make your election as web traffic and SHBP phone volumes are unusually heavy near the end of OE.

STATE PERSONNEL ADMINISTRATION (SPA) FLEXIBLE BENEFITS PROGRAM PARTICIPANTS

- Flexible Benefits Annual Enrollment. If you are eligible to make benefits elections under the Flexible Benefits Program, administered by the State Personnel Administration (SPA), please visit www.GaBreeze.ga.gov or call 3GBreez (877-342-7339) to make your annual enrollment benefits elections. After confirming your elections online, print your confirmation showing your successful completion and keep it for your records. If you choose to call GaBreeze to make your benefit elections, you may request a confirmation be mailed to you. GaBreeze does not include your health election. You will make two confirmations: one for flexible benefits and a separate for confirmation for your health benefits.
- State Health Benefit Health Election. From the GaBreeze website, you have the ability to link to the State Health Benefit Plan (SHBP) for making your health election or may link directly to the SHBP at www.myshbp.ga.gov. After you complete your health election, print your confirmation page that contains your confirmation number and shows your successful completion.

BOARD OF EDUCATION OR AGENCIES NOT PARTICIPATING IN THE SPA FLEXIBLE BENEFITS PROGRAM

- Since you are not a participant of the State of Georgia Flexible Benefits Program, you will make your health election on www.myshbp.ga.gov. After you make your health election, print your confirmation and make sure it contains a confirmation number. This number confirms your health benefit election for the 2012 Plan Year. Contact your personnel/payroll office to obtain information regarding your other flexible benefits sponsored by your Board of Education.

WHAT HAPPENS IF I DON'T GO ONLINE DURING OPEN ENROLLMENT?

- If you do not make an election and are in the HRA, HMO or HDHP Plan, your coverage will default to the Standard HRA, HMO or HDHP Option with your current vendor and any applicable surcharges will apply.
- If you have the HRA Option and elect another option, any unused HRA dollars will be forfeited.

IMPORTANT REMINDERS

- 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.
- Remember you only have 31 days before or after a qualifying event to add a dependent (90 days for a newborn).
- Remember to keep your address current. Only you or your authorized designee can change your address.

PENALTIES FOR MISREPRESENTATION

If an SHBP participant misrepresents eligibility information when applying for coverage, during change of coverage or when filing for benefits, the SHBP may take adverse action against the participants, including but not limited to terminating coverage (for the participant and his or her 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.

OE ELECTION ERRORS

- You may view your OE election after OE ends at www.myshbp.ga.gov.
- You need to check your health deduction on your December check to verify the correct deduction was taken.
- If you feel an error was made when making your election, you must notify your HR Department and they must submit your corrected election to us by December 31. No corrections will be made after your coverage goes into effect on January 1, 2012. See page 3 for more details.

UNDERSTANDING YOUR PLAN OPTIONS

Whether you are enrolled in one of the Wellness or Standard Plan Options, the plans provide 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.

Please keep in mind, if you change options or vendors (CIGNA or UnitedHealthcare) during the year, any amounts applied toward your deductible or out-of-pocket are not transferred to the new option.

HEALTH MAINTENANCE ORGANIZATION (HMO)

A HMO provides major medical, treatment of illness including pharmacy coverage only when using in-network providers (except in cases of emergencies). This Plan features certain services that are subject to a deductible and co-insurance which count toward your out-of-pocket maximum. However, co-payments do not count toward your deductible or out-of-pocket maximum. Although you are not required to obtain a referral to a specialist (SPC), you are encouraged to select a PCP to help coordinate your care. See pages 15-22 for more information.

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. Because this Plan has a deductible that must be satisfied and co-insurance amounts used to meet your out-of-pocket maximum, the amount funded by SHBP into your HRA is used to help 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.**

To illustrate how this works, the following is an example of how your HRA fund can help lower some of your medical out-of-pocket expenses. In the new Wellness Plan Option with family coverage, the money funded by SHBP can help cover the first $1,500 of your out-of-pocket expenses. This will lower your family deductible of $3,250 to $1,750. Once the remainder of the deductible has been satisfied, the Plan pays 85% of your in-network expenses or 60% of your out-of-network expenses until you reach your out-of-pocket maximum. Once your out-of-pocket maximum has been met, the Plan pays at 100%.

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.

One special benefit for enrolling in the Wellness HMO or Wellness HRA Plans is that certain drug costs are waived if SHBP is primary and you participate and remain compliant in one of the Disease State Management (DSM) Programs for Diabetes, Asthma and/or Coronary Artery Disease.

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

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

- Effective January 1, 2012, 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 retirees must make a request within 31 days in order to re-enroll in an SHBP coverage option.
- Retirees who elect TRICARE Supplement Plan coverage may discontinue TRICARE Supplement Plan coverage and re-enroll in SHBP coverage in the future as long as they maintain continuous coverage with either the TRICARE Supplement Plan or SHBP coverage and properly submit the required change forms to SHBP during the OE.

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.

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. However, 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 don't sign up for Medicare Part D Plan if still working or the MA Plan when you first become eligible, you may be charged a late enrollment penalty even if you are working. 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).

IF YOU ARE RETIRING

WHAT YOU NEED TO KNOW IF YOU ARE RETIRING

- If you want to continue your SHBP health insurance coverage after you retire, you and any dependents you want covered must be enrolled in the coverage at the time you retire (please refer to the Retiree Decision Guide for detailed information).
- If you are retiring and under age 65, the Tobacco Surcharge and Spousal Surcharge will apply the same as for active members.
- Once retired, you will have an annual Retiree Option Change Period (ROCP) that allows you to change your Plan Option only. You may add dependents ONLY within 31 days of a qualifying event.
- SHBP will remain your primary coverage until you or any of your covered dependents become eligible for Medicare.
- The premiums you pay and your options change when you or one of your dependents become eligible for Medicare because of age (65 years) or disability.
- You will pay a monthly premium for Medicare Part B coverage through Social Security. You must continue to pay this Part B premium to be eligible for a Medicare Advantage option through SHBP.

GENERAL MEDICARE INFORMATION AND SHBP MEDICARE POLICY

Medicare is the country's health care system for individuals at age 65 or those with certain disabilities. Medicare includes Parts A - hospitalization, B - provider services and D - prescription drugs.

STATE HEALTH BENEFITS PLAN MEDICARE POLICY

SHBP Medicare Policy requires all retirees and spouses eligible for Medicare because of age to enroll in one of the four Medicare Advantage PPO Options offered through CIGNA /Humana Alliance and UnitedHealthcare (UHC) in order to continue to receive the State contribution to the cost of premiums. We will refer to these options as the MA PPO Options. To enroll in a MA PPO Option, you must at least have Medicare Part B coverage
.

- You should enroll for Medicare when you first become eligible and should mail a copy of your Medicare card or approval letter to SHBP, P.O. Box 1990, Atlanta, GA 30301 or fax to a secure fax line at 866-828-4796. To allow time for processing and to avoid paying higher premiums, you should submit this information by the first of the month prior to the month you turn age 65. Upon receipt, SHBP will adjust your premiums to reflect your Medicare.
- Members and/or their dependents eligible due to disability will be responsible for notifying SHBP of their Medicare enrollment as soon as they are eligible.
- SHBP is not able to refund premiums when notification is not received timely.
- SHBP will pay primary benefits on members not enrolled in Medicare but you will pay 100 percent of the cost of your SHBP premiums. Premiums will range from $700 to $3,000 per month.
- Family members not eligible for the MA will keep their current option. This is called split eligibility.

WHAT IF I HAVE END STAGE RENAL DISEASE (ESRD) ?

If you have Medicare due to End Stage Renal Disease (ESRD), you will need to contact the Social Security Administration to determine when Medicare becomes primary.
Medicare information is available at:

- www.cms.hhs.gov
- www.medicare.gov
- www.ssa.gov
- 1-800-669-8387 (Georgia Cares)
- 1-800-633-4227 (Medicare)
- Please send SHBP a copy of the notification from Social Security of your start date to P.O. Box 1990, Atlanta, GA 30301-1990. If you are under 65, eligible for Medicare due to ESRD, in your 30 month coordination period and wish to enroll in a Medicare Advantage option you must select the Humana option offered by SHBP through the CIGNA/Humana alliance. Both vendors can offer Medicare Advantage after the 30 month coordination period ends for ESRD.

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 INFORMATION

- There is critical information about SHBP options and premiums for retirees in the retiree decision guide. It is your responsibility for reading this information.
- The HDHP is not considered a creditable plan.
- If you delay Medicare enrollment because you are still working, there is no penalty for enrolling when you retire unless you are enrolled in the HDHP option. You will be charged a Late Enrollment Penalty (LEP) if you do not enroll when first eligible.
- If you have questions about your SHBP options and premiums when you plan to retire, call the SHBP Call Center at 800-610-1863.

WHAT HAPPENS IF I HAVE THE HRA AND MOVE TO THE MA PPO OPTION?

- Any outstanding funds in the HRA of $100 or more will be moved to a stand alone HRA account to be used toward any out-of-pocket expenses.

Benefits Comparison: Wellness HRA – HDHP – HMO Plans

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

	Wellness HRA Option		Wellness HDHP Option		Wellness HMO Option
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-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*		$1,500 $3,000 $3,000 $3,000	$3,000 $6,000 $6,000 $6,000	$1,000 $1,500 $1,500 $2,000
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*		$2,400 $4,100 $4,100 $4,100	$5,300 $9,800 $9,800 $9,800	$3,000 $4,500 $4,500 $6,000
HRA Credits • You • You + Spouse • You + Child(ren) • You + Family	$500 $1,000 $1,000 $1,500		None		None
Physicians' Services	*The Plan Pays*		*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	90% coverage; subject to deductible	60% coverage; subject to deductible	100% after a $35 PCP or $45 SPC per office visit co-payment
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	100% coverage; not subject to deductible
Maternity Care (prenatal, delivery and postpartum)	85% coverage; subject to deductible	60% coverage; subject to deductible	90% coverage; subject to deductible	60% coverage; subject to deductible	100% after initial $35 co-payment
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	90% coverage; subject to deductible	60% coverage; subject to deductible	80% coverage; subject to deductible

Benefits Comparison: Standard HRA – HDHP – HMO Plans

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

	Standard HRA Option		Standard HDHP Option		Standard HMO Option
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-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	$1,000 $1,500 $1,500 $2,000
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	$3,000 $4,500 $4,500 $6,000
HRA Credits • You • You + Spouse • You + Child(ren) • You + Family	$375 $650 $650 $1,000		None		None
Physicians' Services	*The Plan Pays*		*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	100% after a $45 PCP or $55 SPC per office visit co-payment
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	100% coverage; not subject to deductible
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	100% after initial $45 co-payment
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	80% coverage; subject to deductible

Benefits Comparison: Wellness HRA – HDHP – HMO Plans

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

	Wellness HRA Option		Wellness HDHP Option		Wellness HMO Option
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network
Physicians' Services	*The Plan Pays*		*The Plan Pays*		*The Plan Pays*
Physician Services for Emergency Care	85% coverage; subject to in-network deductible		90% coverage; subject to in-network deductible		100% ($150 co-payment applies to facility expenses)
Outpatient Surgery • When billed as office visit	85% coverage; subject to deductible	60% coverage; subject to deductible	90% coverage; subject to deductible	60% coverage; subject to deductible	100% ($35 PCP or $45 SPC co-payment if billed as office visit)
Outpatient Surgery • When billed as outpatient surgery at a facility	85% coverage; subject to deductible	60% coverage; subject to deductible	90% coverage; subject to deductible	60% coverage; subject to deductible	80% coverage; subject to deductible
Allergy Shots and Serum	85% coverage; subject to deductible	60% coverage; subject to deductible	90% coverage; subject to deductible	60% coverage; subject to deductible	100% for shots and serum after a $35 PCP or $45 SPC per visit co-payment; no co-payment if office visit not billed
Hospital Services	*The Plan Pays*		*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	90% coverage; subject to deductible	60% coverage; subject to deductible	80% coverage; subject to deductible
Inpatient Services • Well-newborn care	85% coverage; subject to deductible	60% coverage; subject to deductible	90% coverage; subject to deductible	60% coverage; subject to deductible	100% coverage; not subject to deductible
Outpatient Surgery Hospital/facility	85% coverage; subject to deductible	60% coverage; subject to deductible	90% coverage; subject to deductible	60% coverage; subject to deductible	80% coverage; subject to deductible
Emergency Care—Hospital • Treatment of an emergency medical condition or injury	85% coverage; subject to deductible		90% coverage; subject to in-network deductible		100% after a $150 per visit co-payment; if admitted, co-payment waived; 80% coverage; subject to deductible
Outpatient Testing, Lab, etc.	*The Plan Pays*		*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	90% coverage; subject to deductible	60% coverage; subject to deductible	80% coverage; subject to deductible

Benefits Comparison: Standard HRA – HDHP – HMO Plans

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

	Standard HRA Option		Standard HDHP Option		Standard HMO Option
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network
Physicians' Services	*The Plan Pays*		*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		100% ($150 co-payment applies to facility expenses)
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	100% ($45 PCP or $55 SPC co-payment if billed as office visit)
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	80% 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	100% for shots and serum after a $45 PCP or $55 SPC per visit co-payment; no co-payment if office visit not billed
Hospital Services	*The Plan Pays*		*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	80% 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	100% coverage; not 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	80% 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		100% after a $150 per visit co-payment; if admitted, co-payment waived; 80% coverage subject to deductible
Outpatient Testing, Lab, etc.	*The Plan Pays*		*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	80% coverage; subject to deductible

Benefits Comparison: Wellness HRA – HDHP – HMO Plans

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

	Wellness HRA Option		Wellness HDHP Option		Wellness HMO Option
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network
Behavioral Health	*The Plan Pays*		*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	90% coverage; subject to deductible	60% coverage; subject to deductible	80% 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	90% coverage; subject to deductible	60% coverage; subject to deductible	100% after $45 SPC per visit co-payment. $10 co-payment for group therapy
Dental	*The Plan Pays*		*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	90% coverage; subject to deductible	60% coverage; subject to deductible	100% after $45 SPC per visit co-payment; if inpatient/ outpatient facility, 80% subject to deductible
	NOTE: Notification required for all UHC options.				
Temporomandibular Joint Syndrome (TMJ) NOTE: Coverage for diagnostic testing and non-surgical treatment up to $1,100 per person lifetime maximum benefit. This limit does not apply to the HMO	85% coverage; subject to deductible	60% coverage; subject to deductible	90% coverage; subject to deductible	60% coverage; subject to deductible	100% after $45 SPC co-payment for related surgery and diagnostic services; excludes appliances and orthodontic treatment; if inpatient/ outpatient facility 80% subject to deductible
Vision	*The Plan Pays*		*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	100% coverage not subject to deductible
Other Coverage	*The Plan Pays*		*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		90% coverage for route exam and fitting; subject to deductible. $1,500 hearing aid allowance every 5 years; subject to the deductible		Not covered
Ambulance Services for Emergency Care NOTE: "Land or air ambulance" to nearest facility to treat the condition	85% coverage; subject to deductible		90% coverage; subject to in-network deductible		100% coverage; not subject to deductible
Urgent Care Services NOTE: All subject to deductible except HMO	85% coverage; subject to deductible	60% coverage; subject to deductible	90% coverage; subject to deductible	60% coverage; subject to deductible	100% after $35 co-payment

Benefits Comparison: Standard HRA – HDHP – HMO Plans

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

	Standard HRA Option		Standard HDHP Option		Standard HMO Option
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network
Behavioral Health	*The Plan Pays*		*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	80% 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	100% after $55 SPC per visit co-payment. $10 co-payment for group therapy
Dental	*The Plan Pays*		*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	100% after $55 SPC per visit co-payment; if inpatient/ outpatient facility, 80% subject to deductible
	NOTE: Notification required for all UHC options.				
Temporomandibular Joint Syndrome (TMJ) NOTE: Coverage for diagnostic testing and non-surgical treatment up to $1,100 per person lifetime maximum benefit. This limit does not apply to the HMO	85% coverage; subject to deductible	60% coverage; subject to deductible	80% coverage; subject to deductible	60% coverage; subject to deductible	100% after $55 SPC co-payment for related surgery and diagnostic services; excludes appliances and orthodontic treatment; if inpatient/ outpatient facility 80% subject to deductible
Vision	*The Plan Pays*		*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	100% coverage not subject to deductible
Other Coverage	*The Plan Pays*		*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 route exam and fitting; subject to deductible. $1,500 hearing aid allowance every 5 years; subject to the deductible		Not covered
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		100% coverage; not subject to deductible
Urgent Care Services NOTE: All subject to deductible except HMO	85% coverage; subject to deductible	60% coverage; subject to deductible	80% coverage; subject to deductible	60% coverage; subject to deductible	100% after $35 co-payment

Benefits Comparison: Wellness HRA – HDHP – HMO Plans

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

	Wellness HRA Option		Wellness HDHP Option		Wellness HMO Option
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network
Other Coverage	*The Plan Pays*		*The Plan Pays*		*The Plan Pays*
Home Health Care Services NOTE: Prior approval required	85% coverage; subject to deductible	60% coverage; subject to deductible	90% coverage; subject to deductible	60% coverage; subject to deductible	100% coverage; UHC up to 120 visits; CIGNA up to 120 days per Plan year
Skilled Nursing Facility Services NOTE: Prior approval required	85% coverage; up to 120 days per Plan year; subject to deductible	Not covered	90% coverage up to 120 days per Plan Year; subject to deductible	Not covered	80% coverage; up to 120 days per Plan year; subject to deductible
Hospice Care NOTE: Prior approval required	85% coverage; subject to deductible	60% coverage; subject to deductible	90% coverage; subject to deductible	60% coverage; subject to deductible	100% 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	90% coverage; subject to deductible	60% coverage; subject to deductible	100% coverage not 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)	90% coverage up to 40 visits per therapy per Plan year; subject to deductible (not to exceed a total of 40 visits combined, including any out-of-network visits)	60% coverage up to 40 visits per therapy per Plan year; subject to deductible (not to exceed a total of 40 visits combined, including any in-network visits)	100% coverage after $25 per visit co-payment; up to 40 visits per therapy per Plan year
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	90% coverage; subject to deductible	60% coverage; subject to deductible	100% coverage after $45 SPC co-payment per visit
Foot Care NOTE: Covered only for neurological or vascular diseases	85% coverage; subject to deductible	60% coverage; subject to deductible	90% coverage; subject to deductible	60% coverage; subject to deductible	100% coverage after $35 PCP or $45 SPC co-payment per visit
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	$20
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	$50
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
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		Tier 1–$50 Tier 2–$125 Tier 3–$225

Benefits Comparison: Standard HRA – HDHP – HMO Plans

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

	Standard HRA Option		Standard HDHP Option		Standard HMO Option
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network
Other Coverage	*The Plan Pays*		*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	100% coverage; UHC up to 120 visits; CIGNA up to 120 days per Plan year
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	80% coverage; up to 120 days per Plan year; subject to deductible
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	100% 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	100% coverage not 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)	100% coverage after $25 per visit co-payment; up to 40 visits per therapy per Plan year
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	100% coverage after $55 SPC co-payment per visit
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	100% coverage after $45 PCP or $55 SPC co-payment per visit
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	$20
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	$50
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
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		Tier 1–$50 Tier 2–$125 Tier 3–$225

SHBP ELIGIBILITY

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.

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.

IMPORTANT NOTE

If you have single coverage and are having a baby, in order for the baby's charges to be covered, you must change tiers to include the baby at birth.

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.

DOCUMENTATION CONFIRMING ELIGIBILITY FOR YOUR SPOUSE OR DEPENDENTS

SHBP requires documentation concerning eligibility of dependents covered under the plan.

- **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.

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.doc.

LEGAL NOTICES

ABOUT THE FOLLOWING NOTICES

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. If the option is not offered, you will be placed in the Standard HMO of the vendor you had before the MA PPO
HRA /HMO	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 and Wellness HMO, CIGNA Standard and Wellness HRA, UnitedHealthcare Standard and Wellness HMO, UnitedHealthcare Standard and Wellness HRA

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 and Wellness HDHP, UnitedHealthcare Standard and Wellness 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

Georgia™

SHBP

State Health Benefit Plan