STATE HEALTH BENEFIT PLAN SPECIAL

# GSRA Newsletter

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# Making Your State Health Benefit Plan Decision for 2011

The Retiree Option Change Period is October 12 through November 10, 2010. During this period, you have the opportunity to change your State Health Benefit option for calendar year 2011.

- If you are under age 65, you **must affirmatively** make a selection **by website**[1] **(www.oe2011.ga.gov), by completing the Personalized Change Form and returning to the State no later than 11/10/10 or by phone (800-610-1863 or 404-656-6322).**
- If you are **under age 65** and you are currently enrolled in the OAP option, your coverage will be automatically changed to the HRA unless you make another selection.
- If you are **under age 65**, you **will be charged an additional $80 (for the Tobacco Surcharge) and an additional $50 Spousal Surcharge (when spouse is covered) unless you answer the questions by website (www.oe2011.ga.gov), completing the Personalized Change Form or by phone (800-610-1863 or 404-656-6322).**
- If you are **age 65+** and your current option is one of the Medicare Advantage options, your current option will continue with a higher premium unless you change your option.
- If you are **age 65+** and want to make a change from Standard to Premium MAP (or vice versa) or you want to change the coverage tier (i.e., family to you+spouse), you can make these changes by completing the Personalized Change Form that was mailed to you or by website (www.oe2011.ga.gov ).
- If you are **under age 65 or age 65+** and currently have "family" coverage and you have only yourself and your spouse, you **should** change your election to "you + spouse."
- If you now have a child or children under age 26 not covered, and you want to add the child (ren) to your coverage, you **must** add them during **THIS** Retiree Option Change Period. (Note: Documentation is required.)

SHBP staff reports that phone lines are very busy and members who continue to experience a busy signal may leave an e-mail message at shbpnoreply@dch.ga.gov and leave their question. SHBP commits to someone from SHBP responding within three business days.

## SHBP Plan Changes

The major changes are:

- The OAP (Open Access Plan) is eliminated.
- Deductibles, copayments, and out-of-pocket maximums are increased.
- Premiums are increased.
- Medicare Advantage Plans will no longer be referred to as PFFS (Private Fee For Service), but a PPO (Preferred Provider Organization).
- Coverage options will increase from two to four tiers—(a) you, (b) you + children, (c) you + spouse, and (d) you + family.

## Evaluating Your Options

**Step 1**: Make sure when you choose a vendor (CIGNA, UHC, or HUMANA) that its network includes a group of providers in the proximity to your residence or work so that medical services can be obtained within a reasonable timeframe.

- If you are **under age 65,** the CIGNA network for HRA, HMO, and HDHP can be found at the website www.mycigna.com/shbp and the UHC network can be found at www.myuhc.com (select the ChoicePlus plan).

[1] **GSRA Advice**: If you are not computer literate, ask a family member or friend to update your option by website (www.oe2011.ga.gov). You can update your website election as often as you like with the last update being accepted by the SHBP as the election you desire. Print and keep a copy of your confirmation from the computer.

- If you are **age 65+,** the new Medicare Advantage PPO network for Humana can be located at www.humana.com/stateofga and a provider directory can be located at www.uhcretiree.com/shbp.
- If you enroll in either the Standard or Premium MAP with either vendor (UHC or Humana), the network providers are those listed in the specific vendor's network. In addition, MAP will accept any provider who is not in the specific network but is in the Medicare program—accepts assignment (accepts Medicare allowance as payment in full) or will file claims (will limit the amount charged over the Medicare allowance).
- Regardless which option you are considering, be sure to check the prescription drug formulary for your prescribed drugs. Assure yourself that your drugs are on the formulary or that you are willing to seek approval from your physician for a generic. Your physician may also consider prescribing another drug that is therapeutically equivalent, which means that it will treat your illness as well as the drug currently prescribed.

**Step 2**

The Department of Community Health is offering options that cover the same medical services regardless—for the most part—of the option. For example, all options cover physicians, hospitals, and prescription drugs. The difference is how much you pay when you receive the medical service. If you have need for specialized medical services, you should contact the vendors (at the numbers in the Retiree Decision Guide) to discuss.

**Step 3**

Evaluate your costs (premium, deductible, out-of-pocket maximum, copays[2] and coinsurance[3]) and the amount of risk that you wish to assume. Although the charts and discussion refer to your maximum cost, your actual cost for the medical services will vary by the number and type of services that you receive.

- Retirees who are under age 65 may choose between the HRA, HDHP or HMO.
  For simplicity, all stated costs are for the individual (you) coverage and only when using a provider in the vendor's network. Remember—the HMO option does not cover out-of-network providers except for emergency medical services. If you use providers that are not in the vendor's network—called 'out-of-network' providers---and you are enrolled in the HRA or HDHP, your cost is higher for these services—40% of allowable charges.

  See the chart below for projected maximum costs.

| **Your MAXIMUM Cost - 2011** | | |
|---|---|---|
| | HRA | HDHP |
| Annual Premium Amount (Monthly Premiums--HRA: $68.75; HDHP:$59.84) | $ 825.00 | $ 718.08 |
| **Maximum Cost When Medical Services Needed** | | |
| Deductible | 1,300.00 | 1,500.00 |
| Less your HRA Credit | -500.00 | .00 |
| You pay 15% of the allowable charges (Rx is 15% for generic and 25% for brand drugs) | 1,700.00 | |
| You pay 10% of the allowable charges (Rx is 20% with a minimum of $10 copay and a maximum of $100) | | 900.00 |
| **Subtotal for Medical Expenses** | **$2,500.00** | **$2,400.00** |
| **Total Medical Expense and Premiums** | $3,325.00 | $3,118.08 |
| Note: The HRA & HDHP covers an annual wellness physical and some wellness procedures at no cost to the member. | | |

Evaluating the cost of the HMO option is a little more complicated. The HMO option has a deductible of $1,000 and an out-of-pocket maximum of $3,000. However, the HMO requires a $35 or $45 copay per office visit, with the remaining cost paid by the HMO. The office visit copay and the prescription drug copay are not subject to the deductible, nor are these copays included in the out-of-pocket maximum.

The types of medical services that are subject to the deductible and out-of-pocket maximum are inpatient services (hospital and physician) and outpatient surgery and non-routine laboratory, x-rays, etc. If you have these services, you would be required to pay 20% of the allowable charges plus the $1,000 deductible – up to $3,000 per year. In summary, most medical services other

[2] Dollar amount that you pay at the point of service.
[3] Percentage of the allowable amount that you pay.

than office visits and prescription drugs are subject to the deductible and out-of-pocket maximum.

| HMO Costs | |
|---|---|
| Annual Premium (Monthly $110.22) | $1,332.64 |
| **Costs when Medical Services Needed** | |
| Deductible | $ 1,000.00 |
| Coinsurance | 2,000.00 |
| **Maximum out-of-pocket, plus copays (office visits and Rx)** | **$3,000.00** |
| Maximum with Premium | $4,332.64 |

You should review medical services for the past year. How many times did you visit the doctor's office? Determine the tier to which your prescribed drugs are assigned. Consider your health condition and if it is compromised such that you are at risk for a hospital confinement or outpatient surgery. Then determine what you think your cost would be under each option that you are considering. Most members will not experience the maximum costs, simply because they will not need medical services at a level that will require the maximum out-of-pocket expense. However, the maximum exposure for each of you is that shown in the charts.

Your decision should be based on the vendor that provides the better provider network for your needs, and the option that does not exclude or limit any specialized medical services that you need, that provides the best formulary for the drugs that are prescribed for you, and your cost analysis. Having enumerated the evaluation points, you may decide to enroll for an option that your analysis shows higher cost, but that you feel will reduce your risk. If such a decision gives you more comfort, then the higher cost option is the option that you should select.

- Retirees who are age 65+ realistically have the choice of vendors (Humana or UHC) and a choice between the Standard and Premium Medicare Advantage PPO Options. After having evaluated the vendor's networks and formularies for prescription drugs, you are ready to determine the costs.

| Medicare Advantage Costs | | |
|---|---|---|
| Annual Premium (Monthly: Standard $21.23; Premium $65.23) | Standard $ 254.76 | Premium $782.76 |
| Out-of-pocket Maximum | 2,000.00 | 1,000.00 |
| Total Premium & OOP | $2,254.76 | $1,782.76 |
| **Note: Rx copays are not included in OOP maximum, but all other copays are included.** | | |

By paying an additional $528 in premium, you can reduce your maximum out-of-pocket costs by $1,000. There are a few other differences, such as a $10 difference in office visit copays and a difference in Rx copay for all tiers except Tier 1. The major difference is the copay for an inpatient hospital stay. The copay is $100 for 5 days under the Premium or $190 for 6 days under the Standard ($500 vs. $1,140). Therefore, if your health is compromised to an extent that you expect a hospital confinement, or you are concerned about the risk of a hospital confinement, the Premium option may be the better option for you.

There are no differences in the services that are covered under the Standard and Premium MAP options. Your actual cost for the medical services will vary by the services that you receive. Your decision about your option should depend on whether you feel that you had rather save premium cost and accept the risk of having a hospital confinement. Your decision should rest on what you think is best for you.

(NOTE: This material is a supplement to the information received from the SHBP. It is not intended to supplant any material received from the State.)

## SHBP Questions & Answers

**The first 21 Questions & Answers shown below were prepared by GSRA for the Annual Membership meeting on October 19, 2010 and have not been reviewed by DCH. The Q&A's are being reprinted here for your information.**

**1. What are the SHBP changes for 2011?**

A: The major changes are:

a. The OAP (Open Access Plan) is eliminated.
b. Deductibles, copayments, and out-of-pocket maximums are increased.
c. Premiums are increased.
d. Medicare Advantage Plans will no longer be referred to as PFFS (Private Fee For Service), but a PPO (Preferred Provider Organization).

e. Coverage options will increase from two to four tiers—(i) you, (ii) you & children, (iii) you & spouse, and (iv) you & family.
f. If enrolled in the Medicare Advantage Plan Options, your enrollment tiers will be based on the 4-tiers just as the under age 65 retirees and enrollment in Medicare.

**2. What options are being offered by the State Health Benefit Plan?**
A: Options offered in CY 2011 are:
i. HMO (Health Maintenance Organization)
ii. HRA (Health Reimbursement Account)
iii. HDHP (High Deductible Health Plan)
iv. MAP (Medicare Advantage Plan)
1. Standard
2. Premium.

**3. If I am 65+ and have Medicare, can I enroll in the HMO, HRA, or HDHP instead of MAP?**
A: Yes, but your monthly premium will be over $1,000, and you must enroll by phoning the SHBP at 800-610-1863 or 404-656-6322.

**4. If I am age 65+, what options do I have during this Retiree Option Change Period?**
A: Realistically, because of the premium cost, most age 65+ retirees have only a choice between the MAP Standard and MAP Premium options. Of course, you may choose another option, but the premiums will be over $1,000 monthly.

**5. How much will premiums increase?**
A: Generally, premiums for all options are increasing by 10%, but if a retiree continues to cover a child, the premium will be increased by an amount above the 10%—from $11 to $15 depending upon the option that you select. The exact premiums will be printed on your Personalized Change Form that is mailed to you by the SHBP.

6. **Retirees in the HMO, HRA, and HDHP will be subject to the tobacco surcharge in 2011. How will the SHBP determine that a retiree uses tobacco and charge the additional $80 per month?**
A: Your Personalized Change Form will include questions that the member must answer about tobacco use. If you don't answer the questions, the surcharge of $80 per month will automatically be added to your premium.

**7. Retirees in the HMO, HRA, and HDHP will be subject to the spousal surcharge in 2011. If my spouse is covered under my insurance, how will the SHBP determine that the spouse is eligible but not enrolled in his/her employer's health plan?**
A: Your Personalized Change Form will include questions about any group coverage for which your spouse may be eligible to enroll. If you don't answer the questions, the surcharge will automatically be added to your premium.

**8. If I have my spouse covered under my plan, will I automatically have to pay the spousal surcharge of $50 per month?**
A: No. The spousal surcharge is charged only when the spouse is eligible to participate in his/her employer's group plan and has chosen not to enroll in that employer's coverage. However, you must answer the questions shown on the Personalized Option Change Form about your spouse and affirmatively complete the enrollment process or you will be automatically charged the $50 surcharge.

**9. If I am now enrolled in the OAP option and I do not make a choice during this Retiree Option Change Period, what will happen to my coverage?**
A: Your coverage will automatically be changed to the HRA option with the vendor that you now currently have.

**10. How much will the deductibles, out-of-pocket maximum, and copays increase for calendar 2011?**
A: The comparison for CY 2010 and CY 2011 for the HMO, HRA, and HDHP options is shown on pages 3 and 4 of your Retiree Decision Guide. Please refer to the Retiree Decision Guide.

**11. How much more will I pay out-of-pocket in addition to my premiums if I enroll or remain in the Medicare Advantage Plan?**
A: Neither the Standard nor the Premium MAP options require a deductible. There are, however, copayments for services—except for an annual physical and certain preventive care services. The comparison showing the increases in the out-of-pocket (copays and coinsurance) cost is displayed on page 17 of your Retiree Decision Guide. The primary increases are shown on the following chart:

| Benefit Category | Standard- You Pay | | Premium-You Pay | |
|---|---|---|---|---|
| | 2010 | 2011 | 2010 | 2011 |
| Out-of-Pocket Maximum | $ 1,000 | $ 2,000 | $ 500 | $ 1,000 |
| Inpatient Hospital Copay | $190 per day (1-4) | $190 per day (1-6) | $100 per day (1-3) | $100 per day (1-5) |
| Outpatient Specialized Scans | $95 copay | 15% of allowable | $50 copay | 10% of allowable |
| Durable Equipment | 10% of allowable | 15% of allowable | 10% of allowable | No change |
| Tier 2 Rx Copay-Retail | $25 | $40 | 25% up to $25 | $30 |
| Tier 2 Rx Copay-Mail Order – 90 days | $50 | $80 | 25% up to $50 | $60 |

12. **Are the Prescription drug copays included in the out-of-pocket maximum cost in the MAP options?**
A: No. All other copays and coinsurance are included in the out-of-pocket Maximum of $2,000 (Standard) or $1,000 (Premium).

13. **What happens to my coverage if I reach age 65 sometime during Calendar 2011?**
A: If you are receiving social security benefits, the Social Security Administration will enroll you in Medicare Part A and Part B, and notify you that you may decline coverage if you so desire (subject to a penalty for late enrollment). If you are not receiving social security benefits, contact the Social Security Administration at least 3 months before the month in which you reach age 65. SSA will assist you in enrolling in Medicare. As soon as you receive your Medicare card, send a copy to the SHBP and you will automatically be enrolled in the MAP Standard option to become effective on the first of the month in which you become age 65. The SHBP will also notify the appropriate retirement system to change your premium. If you prefer enrolling in the MAP Premium option, you will need to notify the SHBP.

14. **What if I fail to notify the SHBP of my enrollment in Medicare?**
A: The SHBP will notify the appropriate retirement system to deduct the much higher premium—over $1,000—for the option in which you are enrolled.

15. **If I am in the HRA option, turn age 65 during the year and enroll in MAP, what will happen to an unused HRA credits?**
A: A separate account will be established by your health care vendor and after six months, the vendor will make the account available for use.

16. **If I am enrolled in MAP, how will I know if my provider is in the PPO network?**
A: You can check the provider networks via the websites or contact the CIGNA/Humana Retiree Help line (800-942-6724) or UnitedHealthcare Retiree Help line (877-246-4190). The websites are www.humana.com/stateofga and www.uhcretiree.com/shbp.

17. **What should I do before I make my 2011 Benefit Election?**
A: Pages 12 and 19 of your Retiree Decision Guide for retirees under age 65 and for Medicare eligible retirees, respectively, provide lists of actions that you should consider before making a decision for your coverage beginning January 1, 2011.

18. **I am under age 65. Do I have to complete an election during this Retiree Option Change Period?**
A: If you are under age 65 and not eligible for Medicare, you must affirmatively make a selection and answer the questions. Otherwise you will be charged the $80 tobacco surcharge and if you have a spouse covered you will be charged the $50 spousal surcharge.

19. **I am over age 65 and already enrolled in MAP. Do I have to complete an election form during this Retiree Option Change Period?**
A: No. The SHBP will default your coverage to your current option and vendor if you do not complete an election. However, if you and your spouse are the only individuals covered, change your coverage tier to "you + spouse" and return the form or enter on the website (www.oe2011.ga.gov).

**20. How do I make my 2011 election?**
A: You may make your selection online at www.oe2011.ga.gov or complete the paper Personalized Change Form. See page 12 of the Retiree Decision Guide for a detailed process if you are under age 65 or enrolling in the HMO, HRA, or HDHP. See page 19 of the Retiree Decision Guide for a detailed process if you are enrolled in MAP.

**21. When can I complete my enrollment materials?**
A: You must complete your election between October 12 and November 10, 2010. If you make your election online, you can complete your selection and then revise that selection as many times as you like as long as the revisions are made by November 10th. The SHBP will update your record with the last revision. If you are completing the paper Personalized Change Form, your form must be postmarked no later than November 10th.

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**The following questions were submitted to the Department of Community Health to respond. DCH staff has graciously responded in writing and their written responses are printed below for your information. Many of these Questions were responded to by DCH staff and representatives from UnitedHealthcare and CIGNA/Humana at the GSRA Annual Membership meeting on October 19, 2010.**

**1. Why is the Open Access Plan being cancelled?**
A: This plan is being cancelled to reduce costs. This plan had the highest per member per month expenses.

**2. Explain what you mean by the tobacco surcharge and how will DCH determine if retirees will be assessed the $80 per month.**
A: The tobacco surcharge charge will be assessed to pre-65 retirees who answer the tobacco surcharge question either on the open enrollment website or the personalized change form that they or their dependents use tobacco products.

**3. Does using tobacco only mean smoking? If not what else is included?**
A: No, This applies to the use of tobacco products such as snuff, dipping and chewing.

**4. Explain how the spousal surcharge will be applied to retirees?**
A: The spousal surcharge will apply to pre-65 retirees whose spouse is eligible for other employer group health insurance and chose not to take it.

**5. Will tobacco and spousal surcharges apply to individuals who are enrolled in one of the MAP options?**
A: It will not apply to retirees and their dependents in the MAP options or who are in the HRA, HDHP or HMO options and are paying 100 percent of the cost. This also applies to retirees who they or their spouses are in the MAP and their dependents are in another SHBP option (referred to as a split option).

**6. We understand that retirees who are enrolled in the HMO, HRA, or HDHP options will now be converted to one of the four-tier coverage tiers. Will over age 65 retirees who are enrolled in MAP have four eligibility tiers also? If so, how will the premiums be determined if all enrollees are not included in Medicare.**
A: All SHBP members whether active or retired will have four tiers and premiums are based on the tier selected, i.e. a retiree in MAP and spouse under 65, the tier would be You+Spouse and the premium would be based on that tier selection.

**7. What are the benefit changes in the SHBP that the national health care reform is requiring in 2011?**
A: (i) Pre-existing has been removed from all SHBP options, (ii) the lifetime maximum benefit limit has been removed, (iii) Children from ages 19 through 25 can be covered regardless of marital status, residency or if a full-time student or eligible for health insurance through their own employment, and (iv) wellness costs are covered at 100% when seeing an in-network provider with no office co-pay or co-insurance.

**8. What has been added to the wellness benefits that have no copayment?**
A: Members will receive the added benefit of the removal of copays for preventive services in 2011. For the HMO option, office visit copays for covered wellness care/preventive health can have been removed and for the Medicare Advantage PPO smoking cessation and Medicare covered annual wellness visit/physical exam will move to a "0" copayment in 2011.

9. **You state in the Decision Guide that all lifetime and annual limits have been eliminated for essential benefits. What are essential benefits?**
   A: The term "essential health benefits" has not yet been defined by the U.S. Department of Health and Human Services (HHS). However, they have generally defined it as a set of health care service categories that include doctor office visits, hospitalizations, and prescription drugs.

10. **What will happen to the retirees who are enrolled in the OAP if the retiree doesn't enroll in another option?**
    A: The retiree will roll to the HRA option and if under 65, the applicable surcharges will be applied.

11. **Your material for the HRA states that if you change options you lose any unused credits. If I reach age 65 and then enroll in MAP, do I lose any unused HRA credits?**
    A: As long as you stay in the HRA option, any unused dollar credits will roll from year to year. If a retiree enrolls in the MAP, any balance of HRA dollars greater than $10 will be rolled to an individual account the retiree can access after a six month run out period.

12. **Why do you have a separate deductible for in-network and out-network providers for the HDHP option and a combined deductible in the HRA option?**
    A: The separate deductible for in-network and out-of-network was due to SHBP plan design. This feature helps to keep member costs down and allows richer benefits under the HRA option.

13. **Explain the situations that would cause a retiree with MAP to permanently lose SHBP coverage.**
    A: If a retiree enrolls in an individual Medicare Part D prescription drug plan or an individual Medicare Advantage Plan, the retiree and his dependents will permanently lose their SHBP coverage unless they return to work in a position that offers SHBP coverage.

14. **We understand that the health care reform act requires plans to allow coverage for a child under age 26. If my child (or other dependent child) (under age 26) was not covered when under age 18, can I enroll him/her during this ROCP?**
    A: Yes. Retirees have a one-time opportunity to enroll any step children who do not reside with them, children who are not full-time students or a child who is over age 26 but was disabled prior to age 26.

15. **If my child (under age 26) was covered under age 18, can I re-enroll him/her during this ROCP?**
    A: Yes.

16. **What documentation is required for the enrollment of a dependent child?**
    A: A copy of the birth certificate that shows both parents' names and social security number. If the child is over age 26 and disabled, disability paperwork is also required.

17. **The Decision Guide states that the Centers of Medicare & Medicaid Services is requiring that national Medicare Advantage Private Fee for Service plans offer a network effective January 1, 2011. Explain what this means to us. Please include in your explanation, the differences that it will mean when we go into a provider's office.**
    A: This is correct. Effective January 1, 2011, retirees will have the choice of a MAP plan that offers a network. This could have been an HMO or PPO network. SHBP decided to offer retirees a MAP PPO option as we felt it would be more advantageous for our retirees. This means that retirees can see a provider who is participating in the vendor's network or who is not participating in the network.

    a. **Are the "deeming" provisions gone?**
       A: Yes.
    b. **If we can continue to use any Medicare provider, what difference does the network make?**
       A: Since there are written contracts with providers, it provides a greater comfort level to our retirees that their providers are participating. It is no longer a verbal agreement.
    c. **When you talk about a Medicare provider are you meaning one who accepts assignment or one in the Medicare program, but doesn't accept Medicare assignment – i.e. will file claims for the patient.**
       A: When referring to a 'Medicare Provider' this is referring to any provider that participates in the Medicare program regardless of if they accept Medicare assignment or not.

**d. If a provider files our claims, but does not accept assignment, who is paid by MAP—the provider or the patient?**
A: The Provider

**18. What happens when we use (for non-emergency) non-network or a non-Medicare provider?**
A: Benefits, your copayments, and coinsurance are the same when you see a provider who accepts Medicare but is not participating in the network. There is no coverage if you see a provider who does not participate in Medicare.

**19. Has either of the vendors contracted with Mayo Clinic? If Mayo Clinic will file my claims as a Medicare provider (not accepting assignment), will MAP pay the claim?**
A: Mayo Clinic in Rochester, Minnesota is participating with Humana Medicare Advantage PPO. The Arizona and Florida locations are non-participating for Humana Medicare Advantage PPO. If the Arizona and Florida locations agree to see members and file claims as not accepting assignment, Humana will pay based on the provider's original Medicare fee schedule.

**20. In a United Healthcare video, there is statement that "as long as the provider is in the network and is seeing you, the provider must accept you." What does this mean? If I have a current doctor seeing me, can he decide to no longer see me as a Medicare patient?**
A: Providers in the UHC Medicare Advantage PPO network must see plan members and accept plan coverage as payment in full (less any applicable member cost sharing). The one exception is that a contracted (in-network) physician may notify the plan that he/she is closing his/her practice to new plan members, in which case no new plan members would be able to see the physician. This would not affect members who are already seeing the physician in question. Physicians who close their practices must do so for all potential new patients in the plan, and may not pick and choose which new patients to accept.

**21. Explain what the statement that "non-contracted providers" will get paid mean?**
For contracted Humana providers, Humana pays the contracted rate. For non-contracted providers, Humana pays based on the provider's original Medicare fee schedule. For UHC out-of-network providers are paid equivalent to what they would receive under Original Medicare. Out-of-Network physicians who do not accept Medicare fee assignment as payment in full but who do participate in the Medicare program are able to balance bill the health plan for the excess charges. (Some states do not allow balance billing and some specialties are not eligible.) Medicare limits the additional amount that the provider can charge called the Medicare limiting Charge. UHC states that the plan (not the member) is responsible for the difference in payment. The member is only responsible for paying his/her copayment or coinsurance. There is never any difference in the member's in-network or out-of-network cost sharing, so members pay the same amount whether the provider or facility is contracted or not.

**22. Why did CIGNA discontinue its Medicare Advantage Plan?**
A: CIGNA did not feel that their network platform was sufficient to meet their MAP objectives so they formed an alliance with Humana who has a strong network. Humana's clinical and wellness programs also provide additional benefits to retirees who participate in these programs.

**23. Has the SHBP conducted an evaluation of the services of Humana?** A: Yes.

**24. What does the statement that the HDHP option is not considered "creditable coverage" mean to retirees? Does it only apply to Part D – Prescription drugs?**
A: Creditable coverage has to do with the prescription drug coverage and whether or not the coverage offered is as good as the coverage under a Medicare Prescription Drug Plan. In the case of the HDHP plan, the coverage is not considered as good as the benefit under a Medicare prescription drug plan. Because of this, if a retiree does not enroll in Medicare when they first become eligible, they will be charged a 1% penalty per year that they do not enroll. This penalty is capped at 19%.

**25. We are hearing and reading a lot of information about insurance companies dropping out of Medicare Advantage and evidently CIGNA has dropped out. What is the likelihood that UHC and Humana will drop out of the MAP contracts?**

A: Humana is fully committed to Medicare Advantage with one of the largest, most efficient and cost effective PPO networks in the country and we anticipate further geographic expansion of the network through 2012. By SHBP partnering with Humana they have selected an industry leader in Medicare Advantage that has continuously participated in the Medicare program for over 25 years and currently serves 3.55 million members under the Medicare Advantage program (1.76 million in MA/MAPD and 1.79 million in Part D prescription drug plans). Despite the impacts of Healthcare Reform, Humana is confident in delivering upon its sustainable value proposition for Medicare Advantage. UHC states that the new law will lead to changes in the Medicare program, but those changes will be phased in over several years. Even with the changes in the Medicare program, UHC remains committed to working with SHBP – now and in the future—to continue to provide its retirees with high quality, affordable health care coverage options.

**26. Is the payment to the providers under the MAP PPO the same as the amount that Medicare Assignment allowed? If different, how is it different? Is it the same for Medicare providers who are not in the respective network?**

A: The reimbursement to providers has no impact on what the member pays when using a Medicare provider. The benefits, copayments and coinsurance are the same.

**27. Are any of the PFFS features and benefits different under the PPO options? Is so, what are the differences – other than copayments and out-of-pocket maximums?**

A: Humana states that the main feature that is different between a PFFS plan and a PPO plan is the requirement of a provider network for PPO plans and that there is no deeming process under the PPO. UHC states that the biggest change to UHC's Medicare Advantage plan for SHBP retirees in 2011 will be that providers no longer need to be 'deemed' under the PPO plan. Aside from changes to some copayments and the annual member out-of-pocket maximum, plan benefits will be unchanged in 2011.

**28. We read articles about the federal government reducing the payment to MAP plans. How will that affect our option for MAP in 2011 and in future years?**

A: Despite the impacts of healthcare reform, Humana is confident in delivering upon its sustainable value proposition for Medicare Advantage. By SHBP partnering with Humana they have selected an industry leader in Medicare Advantage. UHC states that the new law will lead to changes in the Medicare program, but those changes will be phased in over several years.

**29. What is the relationship between UHC and Secure Horizons? Some providers say that they will not participate with Secure Horizons.**

A: UHC and Secure Horizons are both brand names used by UnitedHealthcare Group. Historically we used both brand names for our Medicare Advantage plans, but we are now transitioning all of our Medicare Advantage plans to the UnitedHealthcare brand. Our Medicare Advantage plan for the SHBP has always used the UnitedHealthcare brand and will continue to do so. All of our Medicare Advantage plans are insured through UnitedHealthcare and are part of the UnitedHealthcare organization. Some providers will accept commercial insurance plans but do not accept Medicare Advantage plans; this may explain the reference to providers not participating with SecureHorizons.

**30. What if my provider is included in Medicare, but refuses to file my claims, what should I do?**

A: Call the Customer Service number on the back of your ID card.

**31. Is there any appeal process for covering specific drugs under the drug formulary or exceptions to the tier coverage if my doctor says that because of my medical condition, I must have this drug?**

Humana states that while not all drugs are covered, Humana Pharmacy Solutions' exception process provides an alternative, so that physicians can provide appropriate care. This option allows the plan to stabilize pharmacy costs through intelligent member cost sharing, while providing members and physicians the freedom of choice. Under the Humana plan, retirees have the right to request a coverage determination, which includes the right to request an exception, the right to file an appeal if we deny coverage for a prescription drug, and the right to file a grievance. If retirees think they need an exception, retirees should contact SHBP Customer Service using

the number on the back of their ID card before trying to fill their prescription at a pharmacy so we can help them through the process. The retiree's doctor must provide a statement to support the exception request.

UHC provides an appeal process. UHC members or their providers may request either a "formulary exception" (a drug that is not on the plan's drug list) or a "tiering exception" (lower "preferred" cost share for covered "non-preferred" drugs). Exceptions require the member's doctor or other prescriber to give the plan a written statement that explains the medical reasons for requesting the exception. Exception requests are responded to within 72 hours for "standard" requests and within 24 hours for "expedited" requests. If the request is denied, the member may appeal this decision. Members may appeal up to a second-level appeal and utilize an Independent Review Organization (IRO). In certain cases, for appeals that meet a certain dollar amount, three additional levels of appeals are available. The appeal process for all of these situations is outlined in the member's Evidence of Coverage and is also included on any correspondence from the plan where an appeal is denied.

**32. What frequently used hospitals and provider groups in the State of Georgia are not included in the UHC and the Humana network?**

A: Humana has a robust & extensive network of doctors in the GA area. As of today, there are no hospitals to our knowledge that do not accept Humana Medicare Advantage PPO. Humana will be sending a communication to the most commonly used providers who had serviced the CIGNA Medicare Advantage membership in 2010. In this communication they provide information on the plan change for SHBP to be administered by Humana and invite providers to contact Humana if they are interested in becoming contracted.

UHC states that Archbold Health System (5 facilities), Northeast Georgia Medical Center, Phoebe Putney Health System (3 facilities), Piedmont system and Athens Regional Medical Center have all indicated that they will not sign a contract with any Medicare Advantage carrier. However, they are currently seeing SHBP retirees under the PFFS plan and have indicated they will continue to do so under the PPO plan. Wellstar and St. Joseph's have also indicated they would not contract, but we have not had an opportunity to confirm they will see SHBP retirees as an out-of-network provider at this time. We are in the process of contacting all non-contracted hospitals in the state of Georgia to confirm they will see SHBP retirees as an out-of-network provider. There is never any difference in the member's in-network or out-of-network cost sharing as long as the provider is in the Medicare program.

**33. What national centers of excellence are not included in the UHC and Humana networks? i.e., Shands, Cleveland Clinic, etc.**

A: Humana' network does not include MD Anderson, John Hopkins and the Mayo Clinic locations in Arizona and Florida. UHC's network does not include The Cleveland Clinic, Shands Hospital and Mayo Clinic. However, Mayo Clinic in Arizona and Minnesota have verbally agreed to bill for the PPO plan as an out-of-network provider. In Georgia, Emory and Northside health systems are centers of excellence and both are in the network. Networks change daily, so contact Customer Service for the most up-to-date information.

**34. What networks should we view to determine if my provider(s) are in the respective network?**

A: For Humana, call Humana Customer Service at 1-800-942-6724 or go to the Humana website at www.humana.com/stateofga/ and look under Tools and Resources. The network is called the Humana Choice PPO (Medicare PPO). UHC has created a directory of all Georgia-based providers in the plan's network, and mailed a copy of this directory to all SHBP retirees currently enrolled in the plan and who live in the state of Georgia.

**35. How much is the State paying to CIGNA & UHC each month for a member enrolled in the MAP options?**

A: The State subsidizes premiums and rates vary based on whether the member has Medicare Parts A and B or Part B only.

**36. What do you think is the probability that the SHBP will not have sufficient funds to pay our claims this year?**

A: None.

**37. Many employers are being required to include on the 2011 W2 information, the value of the medical**

**plan. What is the value of the various options under the SHBP? If the information is not yet available, when do you expect to produce the information?**

A: The requirement to include the value of medical plans on the 2011 W2 haw been delayed by IRS. SHBP will not be addressing this issue until further guidance is received from IRS.

38. **The HealthCare.gov website states that the Department of Community Health has been approved for reimbursing some of the cost of SHBP retirees under age 65. However, an asterisk states that the reimbursement is limited to retirees after 10/1/2010. What is the amount of funds that DCH expects to receive during FY 2011 and FY 2012?**

A: The * indicates that the date the State of Georgia, Department of Community received approval of the application was after October 1, 2010. SHBP hopes to receive approximately $50 million during FY 2011. These dollars were included when determining benefits and premiums for the 2011 Plan Year. SHBP anticipates receiving approximately $110 million in FY 2012.

39. **Why does DCH insist on withholding the employer share of premiums for Medicare eligible members who want to enroll in any SHBP option other than MAP?**

A: First, there is no collection of employer premiums that is specifically earmarked for retirees. There are two costs to SHBP associated with retirees—current costs and other post-employment benefit costs (OPEB) which are future costs to the plan. For current costs, the amounts collected from employers must produce enough revenue to cover all SHBP members. The decision to discontinue the state contribution toward retiree's coverage for all options except the MAP was a financial decision as the MAP options are fully insured and costs are set and predictable each year (risk is taken by the MAP, not DCH). Secondly, the calculations for OPEB are lower with the MAP strategy.