The State Health Benefit Plan (SHBP) is a health insurance plan operated by the Department of Community Health (DCH) for the benefit of employees and retirees from State departments and teachers, employees, and retirees from local school systems. This document is prepared to respond to some of the common and background questions regarding the SHBP and the upcoming changes—allowing the DCH staff to respond to other very important questions at the October 21 Annual Meeting Q&A session

January 1, 2010 Changes: Premium rates for all options are increased by 10%, benefits are reduced, and while retirees age 65+ are not literally forced into a Medicare Advantage Plan (MAP), they are being given strong incentives to change to the SHBP MAP.

1. **What are the premium rates for 2010?**
   A: See the GSRA Newsletter of September 15, 2009 or of October 2, 2009 for the rates that are effective for 90% of retirees. If your premium category is not shown, you will receive by mail from DCH an individualized statement showing the premium rates.
2. **Why do the rates published in the GSRA Newsletter for the HMO, PPO (OAP), HRA, and HDHP for retirees age 65+ show a much greater percent increase than 10%?**
   A: DCH changed the premium policy to eliminate all state subsidies to the HMO, PPO (OAP), HRA, and HDHP premiums for retirees age 65+; therefore the published rates reflect the entire cost of the option.
3. **What benefits in the PPO (OAP), HMO, HRA, and HDHP options are reduced?**
   A: The GSRA Newsletters of September 15th and October 2nd highlight the changes. Basically, the deductibles were increased by $100, the office visit and Rx copays are increased by $5 to $10, coinsurance rates are increased from 10% to 20%, and out-of-pocket (OOP) maximums are increased by $500. All of the changes will expose active members and retirees under age 65 to a higher out-of-pocket (OOP) cost in 2010 than in 2009.
4. **What is meant by the Medicare Advantage Plan (MAP), UnitedHealthcare (UHC) MedicareDirect, and CIGNA Medicare Access Plus Rx (PFFS)?**
   A: "Medicare Advantage" is Medicare's title for a plan in which Medicare pays an insurance organization a flat rate each month to insure all health care to an enrollee. There are several kinds of Medicare Advantage Plans, but the one being offered to SHBP retirees is called a "Private Fee-For-Service (PFFS)" plan. UHC calls its MAP the MedicareDirect plan and CIGNA calls its MAP Medicare Access Plus Rx (PFFS).
5. **I was a member of the Kaiser Permanente Senior Advantage Plan. What is the difference in what the SHBP is offering with UHC and CIGNA and the Kaiser Plan?**
   A: The Kaiser Permanente Senior Advantage Plan is also a Medicare Advantage Plan, but it is an HMO product rather than "Fee-For-Service."

Common questions about the Medicare Advantage Plan are answered below. DCH has negotiated the Standard and Premium MAP options so that annual out-of-pocket (OOP) maximums can be held to $1,000 and $500, respectively.

6. **What is the difference between a Medigap (Medicare Supplement) and the Medicare Advantage Plan?**
   A: A Medigap plan pays secondary benefits after Medicare pays and is therefore a 'supplemental' policy to Medicare. Prior to 2010, the SHBP HMO, PPO, HRA, and HDHP options served as employer supplemental plans. Medicare has designed (and strictly controls) the types of Medigap plans that insurance companies are permitted to sell. These plans are labeled by letter from "A" to "L." Benefits under the Medigap plan "F" are similar to the 2009 SHBP PPO. The

2009 monthly premium cost for the "F" policies in the State of Georgia ranges from $46 to $260[1].

The MAP plan, however, is an integrated plan covering all medical services. Think of MAP like a SHBP option—covering all services under one plan—before you enrolled in original Medicare.

7. **Can I enroll in a Medigap Plan with MAP?**
   A: No. You cannot enroll in a Medigap Plan and be enrolled in the SHBP MAP. If you enroll in a Medigap Plan, you lose your SHBP MAP and cannot re-enroll in a SHBP option.
8. **Will Medicare pay first and then MAP pay as the secondary coverage?**
   A: No, even though you are considered to have Medicare coverage and will continue to pay the Medicare Part B premium. No secondary payment is made because the MAP will pay the provider the entire amount of the cost that is allowable under Medicare.
9. **Will I have to pay Medicare Part D premiums?**
   No, MAP will cover prescription drugs without your having to pay Part D Premiums.
10. **Is there a gap (donut hole) in the prescription drug benefit?**
    A: No. The MAP provides an Rx plan with a copay—no deductible and no gap. When you have reached an OOP cost of $4,550 for Rx expense, your copay is reduced.
11. **What will I have to pay out-of-pocket with MAP**?
    A: The amount of out-of-pocket (OOP) cost will vary by whether you enroll for the MAP Standard or MAP Premium. OOP will also vary based on the type and number of medical expenses that you actually incur. See the article "Evaluating your Health Insurance Options for 2010" in the GSRA October 2nd Newsletter. As a general rule you will pay more out-of-pocket at the point of medical service than you paid in 2009. You will, however, save on your premiums. However, some retirees who enrolled in MAP for 2009 state that they have saved money on their Rxs during the year. The primary differences are:
    - You pay a $20 copay in the Standard MAP for each primary care Office Visit, but can reduce it to $10 by enrolling in the Premium option. Unless you were in the HMO during 2009, you did not have to pay an office visit copay.
    - In the Standard MAP you pay $190 per day for the first 4 days ($760) of a hospital admission, but can reduce it to $100 per day for the first 3 days ($300) by enrolling in the Premium MAP. In 2009, unless you were in the HMO, you had to pay only for personal items for a hospital confinement. Medicare and your SHBP option (your Medicare 'supplement') most likely paid the entire bill.
    - You pay $50 for each emergency room visit (unless admitted) in either the Standard or Premium MAP options. During 2009, unless you were in the HMO, Medicare and your SHBP option mostly likely paid the entire bill.
    - You can reduce your copays for drugs in tiers 2, 3, or 4 in the Premium MAP as long as the allowable price is under $100. Your 2009 Part D Prescription Drug plan probably required about the same copays as the copays in MAP although the copays could be higher or lower depending on the type of Part D plan that you had.
    - In the Standard MAP, you pay a $1,000 OOP maximum plus the office visit and Rx copays, but in the Premium option you can reduce the OOP maximum to $500 plus the office visit and Rx copays.
12. **Should I remain in my current SHBP option and original Medicare?**
    A: If you remain in any of the SHBP options (other than MAP), you will have a great deal

[1] Medicare website—http://www.medicare.gov/MPPF/Include/DataSection/Questions/SearchOptions.asp

more cost in 2010 than you had in 2009. In addition to the much higher premiums, you will pay more when you receive medical care because of the change in the Coordination of Benefits (COB) policy, increased deductibles and increased copays. There may be a scenario where you should remain in your 2009 option despite these higher costs, but NONE has been presented to date. However, only you can evaluate your own situation and make the decision that is right for you.

Generally, the MAP options include the same medical coverages as the HMO, PPO (OAP), HRA, and HDHP. Most of the differences other than the network are cost differences. Additionally, the medical coverages between the Standard MAP and the Premium MAP are generally the same.

13. **Are wellness (preventive) benefits included in the MAP plans?**
    A: Yes. Preventive services, such as colorectal screening, pap smears, annual prostate cancer screening, annual routine physical examination (with office visit copay), and flu vaccine are covered.
14. **Are there benefits in the MAP options that are not covered under original Medicare and the HMO, PPO (OAP), HRA, and HDHP?**
    A: Yes. MAP covers an additional 20 routine chiropractic visits per year—much like the SHBP options. MAP also covers a routine eye exam every 12 months, up to $125 for eyewear (or contact lens) every 24 months, routine hearing tests for hearing aids, up to $1,000 for a hearing aid every 48 months, and other benefits as indicated in the SHBP materials.
15. **What is the difference between the Standard and Premium MAP options?**
    A: Coverage for the types of medical care are the same under both options. The premium for the Premium MAP option is $480 more annually ($40 each month per person) than the Standard MAP option. However, the maximum out-of-pocket cost under the Premium MAP is $500 and under the Standard Option is $1,000. Much of the cost difference is for the hospital or skilled nursing facility copays. However, you can save $10 per office visit for primary and $5 per office visit for the specialist under the Premium MAP option. In some cases, you may save copay amounts for Tier 2, 3, or 4 prescription drugs.
16. **Is the $1,000 out-of-pocket (OOP) maximum under the Standard MAP option or the $500 under the Premium MAP option the only out-of-pocket cost for me—except for the premium?**
    A: No. Office visit copays and Rx copays are not included in the OOP maximum. Material from CIGNA indicates that the coinsurance for Medicare Part B drugs and durable medical equipment purchased at a pharmacy is not included in the OOP. UHC indicates that these coinsurance amounts are included in the OOP.

Under the MAP options, a member has the extra benefit of a "mail-order" prescription program. Other SHBP options do not offer the choice between retail and mail order programs.

17. **If I enroll for a MAP option, can I still use my retail pharmacy?**
    A: Yes.
18. **Will my cost be less by using the mail order program?**
    A: Mail order requires you to pay only two copays for a 90-day supply of the drug rather than three 30-day copayments you will pay at the retail pharmacy. Therefore, you will save one copay every 3 months. However, there are several pharmacies that sell specific generic drugs for $4 for a 30-day supply or $10 for a 90-day supply. In this case, your generic copay (amount) MAY be less at the retail pharmacy.

DCH's administrative process: SHBP members who are age 65+ will automatically be moved to the Standard MAP of the vendor that the retiree currently uses if no choice is selected. Medicare will automatically drop the individual's Part D drug plan effective January 1st. You will receive a new ID card for medical services on and after January 1st. Members who turn 65 during 2010 should change to a Medicare Advantage Plan effective the first of the month in which the member turns 65.

19. **If I am 65 and my spouse is under age 65, can my spouse continue or change to the HMO, PPO, HRA, or HDHP?**
    A: Yes, if you have family coverage, the under age 65 member of the family can choose any of the options as long as it is with the same vendor, CIGNA or UHC.
20. **When do I have to make a decision about my 2010 coverage?**
    A: You must make an election during the Retiree Option Change Period, which is from October 9 through November 10, 2009. If you do not make an election, SHBP will move you (provided your record shows Medicare Parts A and B or Medicare Part B coverage) to the Medicare Advantage Plan of the vendor you chose for 2009.
21. **I will turn 65 during 2010. Will SHBP send me something that tells me what I need to do?**
    A: Yes. SHBP sends a letter to each individual about 4 months before reaching age 65. The letter will tell you what you need to do, including sending a copy of your Medicare card to the SHBP in sufficient time for the retiree pension to be adjusted for the reduced premium.
22. **In 2009, I enrolled in the HRA and have not used all of the HRA credit. What will happen to the credit that we were told would roll to 2010?**
    A: You will be able to retain the unused amount in 2010.

The Medicare Advantage (PFFS) option does not have a provider network per se. However, any provider that accepts Medicare and the vendor payment conditions is eligible to become a "deemed provider."

23. **How do I ensure that my provider will become a "deemed provider" for MAP?**
    A: The provider can make the choice on a case-by-case basis. You should contact your provider before services are provided to ask about acceptance of the "SHBP Medicare Advantage Private Fee-For-Service plan." Take the document that the SHBP provided to you to the provider. This document outlines the basic requirements to become a "deemed provider."
24. **What should I ask my provider?**
    A: Be sure to ask if the provider accepts the *"SHBP Medicare Advantage Private Fee-For-Service plan."* CIGNA and UHC market a different MAP to the public. Also, be sure to show your identification card from the SHBP vendor each time you receive services.
25. **What are the requirements for becoming a "deemed provider?"**
    A: Any provider that accepts Medicare assignment or agrees not to bill the patient more than is paid by the SHBP vendor (CIGNA or UHC) can become a "deemed provider." The provider must file the claim directly with the SHBP vendor for payment—not with Medicare.
26. **Do you mean that if I call CIGNA and UHC they cannot tell me if my provider will accept the MAP PFFS plan?**
    The MAP PFFS does not have a network and the provider can choose on a service-by-service basis whether to accept "deemed" status. UHC and CIGNA can, however, search a historical file to let you know if your provider has previously accepted MAP.