SHBP
State Health Benefit Plan
A Division of the Georgia Department of Community Health

My 2018 SHBP Decision Guide

Active Employee

Open Enrollment October 16 - November 3, 2017

www.mySHBPga.adp.com

Resources/Contact Information State Health Benefit Plan (SHBP)

Medical Claims Administrator	Member Services	Website
Blue Cross and Blue Shield of Georgia (BCBSGa)		
Member Services: Monday thru Friday, 8:00 a.m. to 8:00 p.m. ET	855-641-4862 (TTY 711)	www.bcbsga.com/shbp
NurseLine (24 hours a day/7 days per week)	866-787-6361	
Fraud Hotline	800-831-8998	
Kaiser Permanente (KP)		
Member Services: Monday thru Friday, 7:00 a.m. to 7:00 p.m. ET.	855-512-5997 (TTY 711)	my.kp.org/shbp
Nurse Advice (24 hours a day/7 days per week)	404-365-0966 800-611-1811	
Appointment Scheduling or Prescription Help: Monday thru Friday, 7:00 a.m. to 7:00 p.m. ET	404-365-0966 800-611-1811	
Wellness Program Customer Service: Monday thru Friday (except holidays), 11:00 a.m. to 8:00 p.m. ET	866-300-9867	
Kaiser Permanente Rollover Account (KPRA) Customer Service Monday thru Friday (except holidays), 11:00 a.m. to 8:00 p.m. ET	877-761-3399	www.kp.org/healthpayment
Fraud Hotline	855-512-5997	
UnitedHealthcare		
Member Services: Monday thru Friday, 8:00 a.m. to 8:00 p.m. ET (24 hours a day/7 days per week for Nurseline support)	888-364-6352 (TTY 711)	www.welcometouhc.com/shbp
Fraud Hotline	888-364-6352	
Wellness Program Administrator	**Member Services**	**Website**
Sharecare (formerly known as Healthways) Member Services: Monday thru Friday, 8:00 a.m. to 8:00 p.m. ET	888-616-6411 (TTY 711)	www.BeWellSHBP.com
Corporate Compliance	844-401-0005 (TTY 711)	
Pharmacy Administrator	**Member Services**	**Website**
CVS Caremark Member Services: 24 hours a day/7 days per week	844-345-3241	http://info.caremark.com/shbp
TTY Line	1-800-231-4403	
Fraud Hotline	877-CVS-2040	
SHBP	**Member Services**	**Website**
SHBP Member Services Monday thru Friday, 8:30 a.m. to 7:30 p.m. ET, Saturday, 8:00 a.m. to 5:00 p.m. ET during Open Enrollment Regular Business Hours: Monday thru Friday, 8:30 a.m. to 5:00 p.m. ET, Saturday, 8:00 a.m. to 5:00 p.m. ET	800-610-1863	www.mySHBPga.adp.com
Additional Information	**Member Services**	**Website**
TRICARE Supplement	866-637-9911	www.selmantricareresource.com/ga_shbp
Social Security Administration	800-772-1213	www.ssa.gov
Centers for Medicare & Medicaid Services (CMS)	**Help Line**	**Website**
24 hours a day/7 days per week	800-633-4227 TTY 877-486-2048	www.medicare.gov

The material in this Decision Guide is for informational purposes only and is not a contract. It is intended only to highlight principal benefits of the SHBP Plan Options. 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 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 Community Health. Premiums for SHBP options are established by the Board of Community Health and may be changed at any time by Board Resolution, subject to advance notice.

Plan Year 2018 Open Enrollment

Welcome to the State Health Benefit Plan's (SHBP) Open Enrollment (OE) for the 2018 Plan Year. OE gives you the opportunity to review your Plan Options and make changes to your coverage based on your needs. Please read this document carefully to ensure you are choosing the option that best meets you and your covered dependents' health care needs.

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Common Health Care Acronyms

BCBSGa	Blue Cross and Blue Shield of Georgia
CMS	Centers for Medicare & Medicaid Services
DCH	Department of Community Health
FSA	Flexible Spending Account
HDHP	High Deductible Health Plan
HIA	Health Incentive Account
HMO	Health Maintenance Organization
HRA	Health Reimbursement Arrangement
HSA	Health Savings Account
KP	Kaiser Permanente
KPRA	Kaiser Permanente Rollover Account
MIA	MyIncentive Account
OE	Open Enrollment
PCP	Primary Care Physician
PPO	Preferred Provider Organization
QE	Qualifying Event
RRA	Retiree Reimbursement Account
SHBP	State Health Benefit Plan
SPC	Specialist
SPD	Summary Plan Description

GEORGIA DEPARTMENT
OF COMMUNITY HEALTH

Nathan Deal, Governor **Frank W. Berry, Commissioner**

2 Peachtree Street, NW | Atlanta, GA 30303-3159 | 404-656-4507 | www.dch.georgia.gov

October 2017

Dear Valued State Health Benefit Plan Member:

Welcome to Open Enrollment for Active Employees for Plan Year (PY) 2018. Open Enrollment elections can be made online at **www.mySHBPga.adp.com** from October 16, 12:00 a.m. through November 3, 2017, 11:59 p.m.

In keeping with the PY 2017 theme of providing stability and consistency in plan choices, SHBP will continue to offer the same plan designs for PY 2018. Blue Cross and Blue Shield of Georgia (BCBSGa) will continue to offer Gold, Silver and Bronze Health Reimbursement Arrangement (HRA) plan options, and a statewide Health Maintenance Organization (HMO) option. UnitedHealthcare will continue to offer both a statewide HMO plan option and a statewide High Deductible Health Plan (HDHP) option. Further, Kaiser Permanente Georgia will continue to provide a fully-insured HMO plan option in the 27-county Metro Atlanta Service Area.

SHBP is excited to announce that CVS Caremark has been selected to administer the pharmacy benefits for SHBP members and their covered dependent(s) enrolled in Blue Cross and Blue Shield of Georgia and UnitedHealthcare non-Medicare Advantage Plan Options for 2018. Additionally, the Wellness program administrator is now Sharecare (formerly known as Healthways). Members will continue to have the option of earning up to 480 well-being incentive credits (960 per member and covered spouse).

Further, members will continue to be able to roll over well-being incentive credits previously earned into 2018, regardless of which plan option or vendor you are within 2017. I encourage members to take advantage of this increased opportunity to reduce your out-of-pocket costs while further enhancing your overall well-being.

Deciding which health insurance offering is right for you and covered members of your family is a complex one to make. I encourage all members to begin considering your options today and to reach out to SHBP Member Services (800-610-1863) when you have questions.

Thank you for participating in ***your SHBP*** and know that DCH remains committed to ***A Healthy Georgia.***

Sincerely,

Frank W. Berry

Welcome
To The Annual Open Enrollment

Welcome to the Georgia Department of Community Health (DCH), State Health Benefit Plan (SHBP) 2017 Annual Open Enrollment (OE) for Plan Year 2018.

During October 16, 2017 at 12:00 a.m. through November 3, 2017 at 11:59 p.m., over 650,000 eligible employees, retirees and their families will have the opportunity to enroll and/or continue to access quality health insurance benefits offered through SHBP.

On behalf of Governor Nathan Deal, Commissioner Frank W. Berry, the Board of Community Health and the entire SHBP team, I encourage you to explore the plan options and enhancements that are available to you for 2018.

Please take a moment to carefully review the Active Employee Decision Guide, as it has been created especially for you to help make an informed decision during the Annual OE. After you carefully review the Active Decision Guide, follow the enrollment instructions through our online web portal www.mySHBPga.adp.com and choose the coverage option you believe offers the best choice for you and your family.

This Active Employee Decision Guide outlines specific benefit changes that will become effective January 1, 2018 and continue through December 31, 2018. In addition to this Guide, you may visit www.shbp.georgia.gov for other helpful tools, including premium costs, qualifying event definitions and more.

Thank you for the opportunity to serve you by offering quality, cost-effective health care coverage that aligns with our mission to promote health and wellness for all of our SHBP members.

Sincerely,

Jeff Rickman
Division Chief, SHBP

2018 Medical and Pharmacy Claims Administrators, Plan Options and Enhanced Benefits

New Pharmacy Benefit Administrator

CVS Caremark has been selected to administer the pharmacy benefits for the State Health Benefit Plan (SHBP) members and their covered dependent(s) enrolled in Blue Cross and Blue Shield of Georgia (BCBSGa) and UnitedHealthcare Plan Options listed below for 2018.

NOTE: This change does **NOT** mean Members will have to go to a CVS pharmacy location for their prescriptions. CVS Caremark has a broad pharmacy network. Members and their covered dependent(s) can continue to use local retail and/or chain pharmacies to obtain their prescription medications. Use CVS Caremark's pharmacy locator tool to find a network pharmacy near you.

Medical Claims Administrators

BCBSGa, UnitedHealthcare, and Kaiser Permanente (KP) will continue to offer SHBP members the Plan Options listed below for 2018.

Plan Option Offerings

Health Maintenance Organization (HMO)

- BCBSGa
- KP (Metro Atlanta Service Area In-Network **only** plan)
- UnitedHealthcare

High Deductible Health Plan (HDHP)

- UnitedHealthcare

Health Reimbursement Arrangement (HRA) without co-pays

- BCBSGa
  - Gold, Silver and Bronze Plan Options

Additional Option

TRICARE Supplement

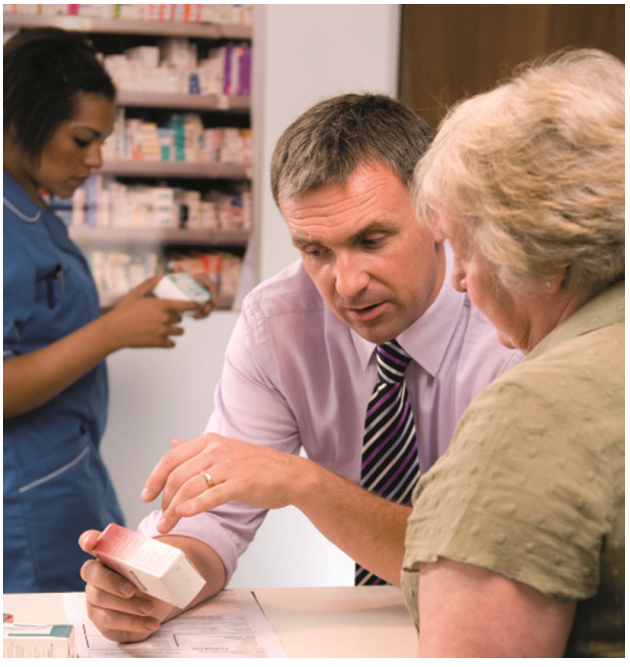
Hearing Aid Benefit

Effective January 1, 2018, the benefit allowance for hearing aids for children up to age 19 has changed from $6,000 every five (5) years to $3,000 per hearing impaired ear every four (4) years.

Well-Being Incentive Credits

BCBSGa and UnitedHealthcare Wellness Incentives

For the past four (4) years the Be Well SHBP Wellness program administrator has been Healthways. Healthways is now owned by Sharecare. Starting in 2018, your health and well-being journey will have a new look and feel. You'll receive personalized health recommendations and activities based on your unique health behaviors and interest in various topics that are important to you. Members will have the option of earning up to 480 well-being incentive credits or up to 960 per employee and their covered spouse. Well-being incentive credits can help offset eligible medical and pharmacy expenses. See the Wellness Section for BCBSGa and UnitedHealthcare Members in this Decision Guide for full details.



Wellness Incentives

2018 WELLNESS INCENTIVES AT-A-GLANCE					
Plan Option	**BCBSGa HMO MyIncentive Account (MIA)**	**BCBSGa Health Reimbursement Arrangement (HRA)**	**Kaiser Permanente (KP)**	**UnitedHealthcare HMO Health Incentive Account (HIA)**	**UnitedHealthcare HDHP Health Incentive Account (HIA)**
Who's Eligible	Up to	Up to		Up to	Up to
Member	480 credits	480 credits	$500*	480 credits	480 credits
Spouse	480 credits	480 credits	$500*	480 credits	480 credits
Bonus credits for member**	N/A	N/A	N/A	240 credits**	240 credits**
Potential Total credits/dollars	960 credits	960 credits	$1,000*	1,200 credits	1,200 credits

KP members and their covered spouses will each receive a $500 Visa gift card after they each satisfy KP's Wellness Program requirements.

****UnitedHealthcare matches the first 240 well-being incentive credits earned by the member only (spouses are not eligible) and credits will automatically be added to your HIA.***

IMPORTANT NOTE: HRA members will receive SHBP-funded base credits at the beginning of the Plan Year. The amount funded will be based on your elected coverage tier. If you enroll in a HRA during the Plan Year, these credits will be prorated based on the elected coverage tier and the months remaining in the current Plan Year.

Important Plan Reminders

Wellness Incentive Credits

If you remain continuously enrolled in a SHBP Plan Option, all unused wellness incentive credits will roll over to the 2018 Plan Year in April. If you do **NOT** change your Medical Claims Administrator or Plan option, your credits will be available January 1, 2018. No matter which Plan Option you select (excluding TRICARE Supplement), you will keep all unused wellness incentive credits

IMPORTANT 2017 WELLNESS NOTE: There is still time for Blue Cross and Blue Shield of Georgia (BCBSGa) and UnitedHealthcare members and their covered spouses to earn the 2017 well-being incentive credits. If you and/or your covered spouse have not completed the required health actions or have not taken any actions, you each have until December 15, 2017 to complete all required actions and submit the 2017 Physician Screening form to earn the 2017 well-being incentive credits. And remember, any unused well-being incentive credits earned in 2017 will roll over in April 2018 to whichever Plan Option and/or vendor you choose to help offset eligible medical and pharmacy expenses during the 2018 Plan Year. If you have questions or need help getting started, visit www.BeWellSHBP.com or contact Sharecare (formerly known as Healthways) at 888-616-6411.

Also, KP members and their covered spouses still have time to participate in KP's 2017 wellness incentive program. KP members and their covered spouses each have until November 30, 2017 to complete all four wellness activities to receive a $500 Visa gift card. Visit KP's website at www. my. kp.org/shbp or contact KP's wellness program customer service at 866-300-9867 for details and if you have questions or need help getting started.

Telemedicine/Virtual Visits

Telemedicine/virtual visits is a benefit that is available to SHBP members under all Plan Options. Telemedicine allows health care professionals to evaluate, diagnose and treat patients using telecommunication technology. Through your plan's participating telemedicine/virtual visit providers, you will be able to see and/or talk to a participating provider from your mobile device, tablet, or computer with a webcam while at home, work, or on the go. Please see the Benefits Comparison Charts in this Decision Guide or contact the Medical Claims Administrators if you have questions.

Applied Behavior Analysis (ABA) for Autism

SHBP provides limited coverage for medically necessary ABA for the treatment of Autism Spectrum Disorder (ASD) to a maximum benefit of $35,000 per year per approved member (through age 10). Applicable co-pays, deductibles and/or co-insurance may apply to all covered services. For more information regarding ABA coverage, please call your Medical Claims Administrator's member service number.

Dependent Verification

Open Enrollment (OE) and certain qualifying events (QE) are opportunities to add eligible dependents to your coverage. SHBP requires documentation confirming eligibility of newly added dependents covered under the Plan. Please see the Eligibility & Enrollment Provisions at www.shbp.georgia.gov for the acceptable documentation. Upon request, be prepared to submit this documentation. If you elect to cover dependents and do not provide documentation necessary to verify eligibility by the deadline, your dependents' coverage will be terminated and no refund will be issued.

NOTE: All members must provide SHBP with their Taxpayer Identification Number (TIN) for themselves and their enrolled dependents. The most common type of TIN is a Social Security Number (SSN), but for individuals who are not eligible for a SSN, members may submit an Individual Taxpayer Identification Number (ITIN) or Adoption Taxpayer Identification Number (ATIN). Failure to submit a TIN will result in a loss of coverage and no refund will be issued.

Summary of Benefits and Coverage (SBC)

SBC documents provide you with standard information that help you to understand, evaluate and compare the Plan Options as you make decisions about which Plan to choose. The SBC documents are available online at www.shbp.georgia.gov and upon request for the following Plan Options: Health Maintenance Organization (HMO),Health Reimbursement Arrangement (HRA) and High Deductible Health Plan (HDHP).

Important Plan Reminders (cont.)

2018 Pharmacy Transition

CVS Caremark will administer the pharmacy benefits for members and their covered dependent(s) enrolled in Blue Cross and Blue Shield of Georgia (BCBSGa) and UnitedHealthcare Plan Options for 2018. Effective January 1, 2018, Express Scripts will no longer administer the pharmacy benefits.

NOTE: This change does **NOT** mean Members will have to go to a CVS pharmacy location for their prescriptions. CVS Caremark has a broad pharmacy network. Members and their covered dependent(s) can continue to use local retail and/or chain pharmacies to obtain their prescription medications. Use CVS Caremark's pharmacy locator tool to find a network pharmacy near you.

2017 Pharmacy Claims

1. Pharmacy paper claims for prescription medication received on or before December 31, 2017 must be filed with Express Scripts no later than December 31, 2018.
2. Any requests for appeals and claim adjustments for 2017 pharmacy claims must be submitted by December 31, 2018.

Specialty Medications

Members receiving specialty medications through Accredo Specialty Pharmacy will be transitioned over to CVS Caremark Specialty Pharmacy. You do not have to obtain a new prescription to continue to obtain your medication(s), unless your prescriptions have expired and/or you don't have any refills left. CVS Caremark Specialty will be contacting all members receiving specialty medications through Accredo Specialty Pharmacy to assists with setting up your medications through mail order and working with your physicians to get new prescriptions, if applicable.

ACTION ALERT

If you or your enrolled dependent(s) experience a qualifying event (QE) during the Plan Year that results in coverage under a new identification (ID) number or a change in Plan Option and/or vendor, your well-being incentive credits will be forfeited. The deductible and out-of-pocket maximum will not be transferred. For members enrolled in a Health Reimbursement Arrangement (HRA) Plan Option, if moving to a new HRA ID number and/or HRA Plan Option, the HRA base funding will be prorated based on the elected coverage tier and the months remaining in the current Plan Year. Deductibles, out-of-pocket maximums and any wellness incentive credit balances are not prorated nor transferrable. For additional information, please reference the Eligibility & Enrollment Provisions at www.shbp.georgia.gov.

Annuitant Subsidy Policies

The State Health Benefit Plan (SHBP) has two subsidy policies that determine the amount of subsidy Annuitants (Retirees) will receive from SHBP to cover the costs of their premiums. The amount of the subsidy a Retiree receives from SHBP lowers the monthly premium amount Retirees pay for their SHBP coverage.

Annuitant Basic Subsidy Policy (Old Policy)

Under the Annuitant Basic Subsidy Policy, the monthly premium amount a Retiree pays for SHBP coverage is the same across all plan options but the percentage varies as the costs of plan options vary.

You are subject to the Annuitant Basic Subsidy Policy if:

1. You were not an active employee on January 1, 2012, but were an Annuitant receiving a retirement check from a State retirement system – ERS or TRS and enrolled in SHBP retirement coverage on January 1, 2012 or;

2. You were not an active State employee on January 1, 2012, but were a former State employee with eight years of service and enrolled in state extended SHBP coverage on January 1, 2012; or you were not an active Teacher or Public School employee on January 1, 2012, but were a former teacher or public school employee with eight years of service in a State retirement system but could not retire due to age and enrolled in state extended SHBP coverage on January 1, 2012, or;

3. You were an active employee that on January 1, 2012 had five years of service in the State retirement system from where you will receive an annuity (ERS or TRS).

Annuitant Years of Service Subsidy Policy (New Policy)

Under the Annuitant Years of Service Subsidy Policy, the monthly premium amount a Retiree pays for SHBP coverage depends on the number of years of service reported to SHBP from the retirement system (ERS or TRS) in which the Retiree is eligible to receive an annuity.

You are subject to the Annuitant Years of Service Subsidy Policy if on January 1, 2012 you did not have five years of service in the State retirement system from where you will receive an annuity.

The subsidy percentage for each member increases with every year of service beginning at 10 years through 30 or more years. Members with 0-9 years of service (i.e., less than 10 years of service) will receive no subsidy.

• For members, the subsidy range is a minimum of 15% for 10 years of service (i.e., 10 years of service = 15% subsidy), and a maximum of 75% for 30 or more years of service (i.e., 30 or more years of service = 75%; and cannot be greater than the subsidy for an Active Employee)

The subsidy amount for each dependent increases with every year of service for the member beginning at 10 years through 30 or more years.

• For dependents, the subsidy range is a minimum of 15% for a dependent if the member has 10 years of service and a maximum of 55% if the member has 30 or more years of service (but cannot be greater than the subsidy for an Active Employee's dependent minus 20%)

Years of Service Reporting to SHBP

When a member retires, the applicable state retirement system (ERS or TRS) will provide SHBP information which indicates whether or not a member had five years of service as of January 1, 2012. For members subject to the new policy (i.e., did not have five years of service on January 1, 2012), each applicable state retirement system will also provide SHBP the number of years of service that a member had upon their retirement. Years of service are determined by the state retirement systems and not by SHBP.

Additional Information

SHBP rate calculators are available online at www.shbp.georgia.gov to assist Retirees with estimating their premiums during the 2018 Plan Year. For questions regarding the New Policy, please contact the SHBP Member Services Center at 800-610-1863.

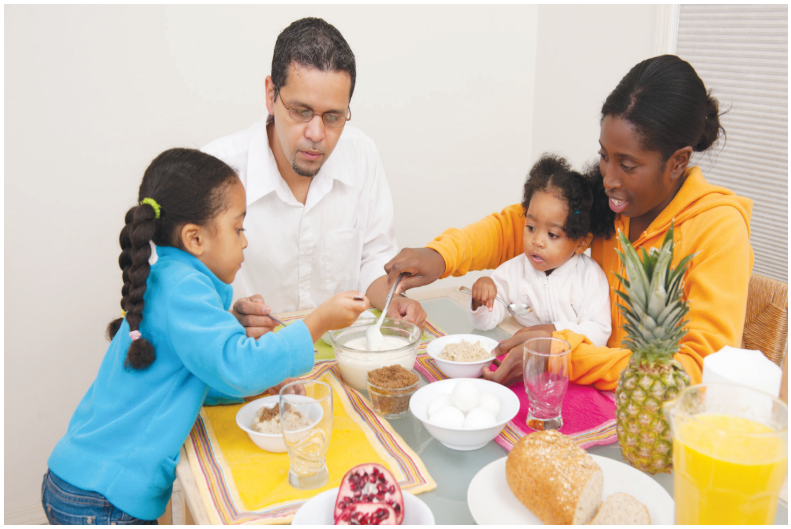
The Board of Community Health sets all member premiums by resolution and in accordance with the law and applicable revenue and expense projections. Any subsidy policy adopted by the Board may be changed at any time by Board resolution, and does not constitute a contract or promise of any amount of subsidy.

Annual Open Enrollment (OE) and Your Responsibilities

Website for the Annual OE available from October 16 at 12:00 a.m. through November 3, 2017 at 11:59 p.m. ET

Your Responsibilities as a State Health Benefit Plan (SHBP) Member

- Make your elections online at www.mySHBPga.adp.com no later than November 3, 2017 by 11:59 p.m. ET
- Read and make sure you understand the plan materials posted at www.shbp.georgia.gov and other information provided by your employer and take the required actions
- Check your payroll deduction to verify that the correct deduction amount has been made. If you are not being charged the correct amount, immediately contact SHBP Member Services
- Update any changes in your address, by notifying your Benefit Coordinator or HR Department
- Notify SHBP whenever you have a change in covered dependents within 31 days of a qualifying event (QE)
- Notify SHBP when you, a covered spouse, or dependent gain Medicare coverage within 31 days, including gaining coverage as a result of End Stage Renal Disease (ESRD)



During OE, you may:

- Elect SHBP coverage
- Change to any Plan Option and/or vendor for which you are eligible
- Enroll eligible dependents
- Drop covered dependents
- Decrease/increase coverage tier
- Discontinue SHBP coverage

IMPORTANT NOTE

- **The election made during OE will be the coverage you have for the entire 2018 Plan Year unless you have a QE that allows a change to your coverage**
- **Enrolling or discontinuing coverage from individual coverage offered through the Health Insurance Marketplace is NOT a QE**

Making Your Health Benefit Election for 2018

Annual Open Enrollment (OE) begins October 16, 2017, 12:00 a.m. ET and ends November 3, 2017, 11:59 p.m. ET

Before making your selection, we urge you to review the Plan Options described in this guide, discuss them with your family and choose a Plan Option that is best for you and your covered dependents. **Due to expected heavy call volume and online traffic, we strongly encourage all members to confirm your access to the enrollment portal in advance of the Open Enrollment (OE) election start date and after OE starts, make your elections early.**

If you experience any technical difficulties, please contact SHBP Member Services at 800-610-1863.

Open Enrollment (OE) begins October 16, 2017, at 12:00 a.m. ET and ends November 3, 2017, 11:59 p.m. ET.

How to Reset Your Password

Go to the Enrollment Portal: www.mySHBPga.adp.com

Step 1: Click Forgot Your Password.

Step 2: Enter Your User ID

Step 3: Follow the instructions to answer a series of security questions

NOTE: If you do not know the answers to the security questions, contact SHBP Member Services at 800-610-1863 to assist you with the password reset process.

Step 4: Create a new Password

Step 5: Click Continue

If you answer the security questions wrong or spell the answer incorrectly (case sensitivity does not apply), you will have two more tries before you are locked out and must begin the process again.

What if I Do Not Take Any Action?

If SHBP does not receive an election from you through the enrollment portal, www.mySHBPga.adp.com or by your contacting SHBP's Member Services if you don't have internet access, you are choosing to remain in your current 2017 Plan Option, tier and medical claims administrator for 2018.

Also, if you are paying the Tobacco Surcharge in 2017, you will continue to pay the Tobacco Surcharge in 2018.

NOTE: It is your responsibility to notify SHBP immediately if you and/or your dependent (s) no longer qualify for the Tobacco Surcharge. Also, it is your obligation to contact SHBP if you and/or your dependent (s) resumes his/her tobacco use. You must notify SHBP if your answer to the Tobacco Surcharge question changes.

If you are enrolled in the TRICARE Supplement in 2017, you will be enrolled in the TRICARE Supplement for 2018.

How to Make Your 2018 Health Benefit Election

Go to the Enrollment Portal: www.mySHBPga.adp.com

Step 1: Log on to the Enrollment Portal. (If you are a first time user, you must first register using the registration code **SHBP-GA** and set up a password before making your 2018 election. If you are a returning user but have not accessed the website since 9/15/17, then you must first reset your password before making your 2018 election). The Home page displays a OE message indicating the event date for you on the top of the screen for elections to be in effect for the 2018 Plan Year.

Step 2: Under the Open Enrollment window, **click on Continue** to proceed with your 2018 Plan Year enrollment.

Step 3:The Welcome page displays a Terms and Conditions message with the new Plan Year as the effective date. You must **click Accept Terms and Conditions** to continue to the next step of enrollment.

Step 4: **Click on Go to Review Your Current Elections.** This screen displays appropriate default enrollments for you.

Step 5: **Click on Go To Review Your Dependents.** Verify that each dependent has a valid Social Security number (SSN) or Tax Identification Number (TIN). To add additional dependents, **click** on Add a Dependent, and enter necessary details to enroll dependents including a valid (SSN) or TIN.

Step 6: To start your Election Process, **click** on **Go to Make your Elections.**

Step 7: **Click** on **Go To Tobacco Surcharge question**. You MUST answer the tobacco surcharge question using the radial buttons.

- After you answer the Tobacco Surcharge question, the Decision Support box will display. You are provided an option to use the Decision Support Benefit Option Comparison Tool to help you choose the right plan to meet your needs. You can choose to decline or accept the opportunity to use the tool. Please see page 10 for additional information regarding the Decision Support Tools.

Step 8: **Click on Go to Health Benefits** to choose your Medical Claims Administrator, Plan Option and coverage tier.

Step 9: Make your elections.

NOTE: When adding a dependent, scroll down and check the "Include in Coverage" box located next to your newly added dependent. For existing dependents confirm that all that require benefits have a check in the "Include in Coverage" box.

- If you choose **NOT** to enroll in a Plan Option you must click the radial button for **No Coverage**. A pop-up box will then display **Reason for Waive**. You will need to select the drop-down box which will populate responses. Next, scroll through the options provided and select a reason. The **Reason for Waive** must be populated to move to the next step.

Step 10: **Click on Go to Review and Confirm Changes**.

- Your Elections (This screen displays your elections made. You should carefully review your elections.)

Step 11: **Click Finish**.

NOTE: If Finish is NOT clicked, your enrollment process has not been completed. After Open Enrollment, all members and their dependents, if applicable, enrolled in Blue Cross and Blue Shield of Georgia (BCBSGa) and UnitedHealthcare Plan Options will be issued new identification (ID) cards.

Open Enrollment (OE) Checklist

- ☑ Verify all desired dependents are listed on the Confirmation Page and have a valid Social Security Number (SSN) or Tax Identification Number (TIN)
- ☑ Verify your coverage tier (you only, you + spouse, you + child(ren) or you + family)
- ☑ Confirm the Plan Option selected shown on the Confirmation Page is correct
- ☑ Confirm that you answered the Tobacco Surcharge question appropriately
- ☑ Confirm that you have clicked Finish
- ☑ Print Confirmation Page and save for your records

NOTE: *You may go online multiple times; however, the last option confirmed at the close of OE will be your option for 2018 unless you experience a qualifying event (QE) that allows you to make a change.*

Take Advantage of Decision Support Tools to Help You Select the Health Care Option that Best Meets Your Personal and Financial Needs!

To help you with your enrollment choices, the State Health Benefit Plan (SHBP) has included Decision Support Tools as part of the Enrollment Portal; using them, you will be provided with personalized, easy-to-understand information to assist you in making educated health care decisions. Decision Support Tools will help you choose the Plan Option that best meets your personal needs and circumstances.

Making Changes During the Plan Year When You Experience a Qualifying Event (QE)

Consider your benefit needs carefully and make the appropriate selection. The election made during 2017 Open Enrollment (OE) will be the coverage you have for the entire 2018 Plan Year, unless you have a QE that allows a change in your coverage. You only have 31 days after a QE to add a dependent (90 days to add a newly eligible dependent child). For a complete description of QEs, see your Eligibility & Enrollment Provisions document available online at www.shbp.georgia.gov.

You may also contact State Health Benefit Plan (SHBP) Member Services for assistance at 800-610-1863.

QEs include, but are not limited to:

- Birth, adoption of a child, or placement for adoption
- Death of a currently enrolled spouse or enrolled child
- Your spouse's or eligible dependent's loss of eligibility for other group health coverage
- Marriage or divorce
- Medicare eligibility
- Loss of Medicaid eligibility (excluding voluntary discontiuation of coverage/non-compliance/payment)

Eligible Dependents

State Health Benefit Plan (SHBP) covers eligible dependents who meet SHBP guidelines. **Eligibility documentation must be submitted before the deadline to avoid termination of your dependent's SHBP coverage.** Eligible dependents include:

- Spouse (includes same sex)
- Dependent Child
  - Natural child
  - Adopted child
  - Stepchild
  - Guardianship -Totally disabled child who is physically or mentally disabled prior to age 26, an is primarily dependent on the enrolled member for support and maintenance

How to Declare a QE

To make a change in enrollment due to a QE, you must log on to the Enrollment Portal at www.mySHBPga.adp.com and declare a QE to make the change. The time limit to declare is 31 days after most QEs.

- Remember you only have 31 days after a QE to add a dependent, e.g., adding a spouse or stepchild
- You have 90 days to add a newly eligible dependent child and submit the Social Security Number (SSN) or Tax Identification Number (TIN)
- Members who do not have web access may call SHBP Member Services at 800-610-1863 and a representative will assist you with making the change
- Documentation to support your declaration is required and will be requested
- If you elect to cover dependents and do not provide documentation necessary to verify eligibility by the deadline, your dependents' coverage will be terminated and no refund will be issued

Flexible Benefits Program

If you are eligible to make benefit elections under the Flexible Benefits Program (e.g., dental, vision) administered by the Department of Administrative Services (DOAS), please visit www.GABreeze.ga.gov or call 877-342-7339 to make your annual enrollment flexible benefit elections.

If your employer does not participate in the DOAS Flexible Benefits Program, contact your personnel/payroll office to obtain information regarding flexible benefits sponsored by your employer.

New Hires

ACTION ALERT

If you are having a baby, you MUST add your newborn child and submit the social security number (SSN) or tax identification number (TIN) within 90 days of the birth in order for the baby's services to be covered. You may also have to change Plan tiers. For a complete description of eligibility, see SHBP's Eligibility & Enrollment Provisions Document available online at www.shbp.georgia.gov.

Coverage Effective Date for New Hires

The effective date of coverage for new hires is the first of the month following one full calendar month of employment, unless the hire date is concurrent with the first of the month. If the hire date is concurrent with the first of the month, then coverage is effective the first of the month following the hire date.
Examples:

- If hired on 10/15/2017, one full calendar month following October is 11/15/2017. Coverage would begin the first month following November, which would be 12/1/2017
- If hired on 11/1/2017, since the hire date is concurrent with the first of the month, coverage would begin the first of the month following the hire date, which would be 12/1/2017
- If hired 1/31/2018, one full calendar month following January is February, and coverage would begin the first month following February, which would be 3/1/2018

Note: If you fail to enroll as a new hire, your next opportunity to enroll in an SHBP option will be during the next annual Open Enrollment period, unless you have a qualifying event that allows a change to your coverage.

2018 Plan Options

The 2018 Plan Options (listed below) are designed to provide members with a choice of Plan Options that best meets their needs.

Blue Cross and Blue Shield of Georgia (BCBSGa)

- Health Reimbursement Arrangement (HRA) without co-pays
  - Gold
  - Silver
  - Bronze
- Statewide Health Maintenance Organization (HMO)

UnitedHealthcare

- High Deductible Health Plan (HDHP)
- Statewide Health Maintenance Organization (HMO)

NOTE: For BCBSGa and UnitedHealthcare, the pharmacy benefits will be administered by CVS Caremark and the wellness benefits will be administered by Sharecare (formerly known as Healthways).

Kaiser Permanente (KP)

The KP Regional HMO (Metro Atlanta Service Area only) offers medical, wellness and pharmacy benefits. You must **live <u>or</u> work** in one of the below 27 counties within the Metro Atlanta Service Area to be eligible to enroll in KP:

Barrow	Coweta	Gwinnett	Paulding
Bartow	Dawson	Haralson	Pickens
Butts	DeKalb	Heard	Pike
Carroll	Douglas	Henry	Rockdale
Cherokee	Fayette	Lamar	Spalding
Clayton	Forsyth	Meriwether	Walton
Cobb	Fulton	Newton	

Additional Options

The TRICARE Supplement will continue to be available for those members enrolled in TRICARE. See pages 29 and 30 for additional information.

CVS Caremark will be the new Pharmacy Benefit Manager (PBM) beginning January 1, 2018. They will administer the pharmacy benefits for members who choose BCBSGa and UnitedHealthcare. CVS Caremark will provide benefits for retail prescription drug products, mail order, home delivery and specialty pharmacy services.

Sharecare (formerly known as Healthways), provides members with comprehensive well-being resources and incentive programs for members who choose BCBSGa and UnitedHealthcare. Sharecare will also administer the 2018 action-based health incentives that will allow these SHBP members and their covered spouses to earn additional well-being incentive credits.

Understanding Your Plan Options For 2018

Important Note: In addition to the Plan Option descriptions below, please read the Benefits Comparison Charts in this guide carefully and look at your medical and prescription expenses to make sure you understand the out-of-pocket costs under each option. You can find premium rates online at www.shbp.georgia.gov.

How the Health Reimbursement Arrangement (HRA) with Blue Cross and Blue Shield of Georgia (BCBSGa) Works

The HRA is a Consumer-Driven Health Plan Option (CDHP) that includes a State Health Benefit Plan (SHBP)-funded HRA account that provides first-dollar coverage for eligible medical and pharmacy expenses. The HRA Plan Options offer access to a statewide and national network of providers across the United States.

It is important to note that when you go to the doctor, you do not pay a co-pay. Instead, you pay the applicable deductible or co-insurance. SHBP contributes HRA credits to your HRA account based on the HRA Plan Option and tier in which you enroll. If you have unused credits in your HRA account from 2017, those credits will roll over to the next Plan Year as long as you remain enrolled in an SHBP Plan Option (excluding the TRICARE Supplement). If you were previously a member of another SHBP Plan Option, all unused 2017 well-being incentive credits will roll over to your 2018 HRA plan or any other Plan Option, in April 2018.

NOTE: There is a date limitation to how the 2017 rollover credits can be used for reimbursement. Only eligible medical and pharmacy expenses incurred after the rollover in April 2018 will qualify for reimbursement using the 2017 rollover credits. Eligible medical and pharmacy expenses incurred between January and March 2018 are not eligible for reimbursement using 2017 rollover credits unless you elect to remain in an HRA Plan Option. If you stay in an HRA Plan Option, rollover credits will be available January 1, 2018. However, until your unused 2017 credits roll over, your 2018 HRA credits funded by SHBP and any well-being incentive credits earned in 2018 and (available at the time claims are received), will be used to offset those eligible medical and pharmacy expenses incurred during this time period.

Plan Features

- There are separate in-network and out-of-network deductibles and out-of-pocket maximums
- After you meet your annual deductible, you pay a percentage of the cost of your eligible medical and pharmacy expenses, called co-insurance
- You do not have to obtain a referral to see a Specialist (SPC); however, we encourage you to select a PCP to help coordinate your care
- The credits in your HRA account are used to help meet your deductibles and your co-insurance
- There are no co-pays
- The medical and pharmacy out-of-pocket maximums are combined
- Pharmacy expenses are not subject to the deductible. Instead, you pay co-insurance. If you have available HRA credits, these credits will be used to pay your co-insurance at the point of sale. Once the credits in your HRA account are exhausted, you are responsible for paying the co-insurance amount at the point of sale
- Certain drug costs are waived if SHBP is primary and you actively participate in one of the Disease Management (DM) Programs for diabetes, asthma and/or coronary artery disease
- If you enroll in an HRA Plan Option after the first of the year, your SHBP-funded base credits deposited into your HRA account will be prorated. However, your deductible and co-insurance will not be prorated
- The Plan pays 100% of covered services provided by in-network providers that are properly coded as “preventive care” within the meaning of the Affordable Care Act (ACA)
- Telemedicine/virtual visits for certain medical and behavioral health services are available, in-network only
- You and your covered spouse are eligible to up to 480 well-being incentive credits each by participating in the SHBP well-being program, Be Well SHBP, administered by Sharecare (formerly known as Healthways)

NOTE: Pharmacy benefits are administered by CVS Caremark and the Wellness benefits are administered by Sharecare (formerly know as Healthways).

How the High Deductible Health Plan (HDHP) Works

The HDHP 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. The HDHP has a low monthly premium. However, you must satisfy a high deductible that applies to all eligible medical and pharmacy expenses (except preventive care). If you have You + child(ren), You + spouse or You + family coverage, the entire family deductible does not have to be met before benefits are payable for an individual family member.

The You coverage tier (single) deductible and out-of-pocket maximum will apply to each individual family member regardless of whether you cover more than one dependent or have family coverage. This means, if your coverage tier is You + spouse, You + child(ren) or You + family, an individual family member only needs to meet the You coverage tier (single) deductible and out-of-pocket maximum and his/her eligible medical and pharmacy expenses will be paid regardless of whether the family deductible has been satisfied. Furthermore, once the You coverage tier (single) out-of-pocket maximum has been satisfied for that individual family member, all eligible medical and pharmacy expenses will be paid at 100% for the Plan Year for that family member.

For example:
An individual that is covered under a family coverage tier, regardless of how many family members are in that tier, will have a maximum individual network deductible of $3,500 and a maximum individual network out-of-pocket of $6,450. The individual out-of-network deductible will not exceed $7,000 and the individual out of network out-of-pocket maximum will not exceed $12,900. Additionally, an individual family member may not contribute more than their own individual deductible or out-of-pocket maximum to the overall family deductible and out-of-pocket maximum.

NOTE: Before well-being incentive credits members must meet the deductible threshold ($1,300 - individual; $2,600 - other tiers).

Also, you may qualify to establish 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.

Plan Features:

- There are separate in-network and out-of-network deductibles and out-of-pocket maximums
- You pay co-insurance after meeting the deductible for all eligible medical and pharmacy expenses until the out-of-pocket maximum is met
- You do not have to obtain a referral to see a Specialist (SPC); however, we encourage you to select a PCP to help coordinate your care
- There are no co-pays
- The medical and pharmacy out-of-pocket maximums are combined
- Before you can use well-being incentive credits, members must meet the deductible threshold ($1,300 - individual; $2,600 - other tiers)
- Certain drug costs are waived if SHBP is primary and you actively participate in one of the Disease Management (DM) Programs for diabetes, asthma, and/or coronary artery disease. Members must satisfy the deductible threshold ($1,300 - individual; $2,600 - other tiers)
- The Plan pays 100% of covered services provided by in-network providers that are properly coded as “preventive care” within the meaning of the Affordable Care Act (ACA)
- Telemedicine/virtual visits for certain medical services are available in-network only
- You and your covered spouse are eligible to earn up to 480 well-being incentive credits each by participating in the SHBP well-being program, Be Well SHBP, administered by Sharecare (formerly known as Healthways)

Members enrolled in UnitedHealthcare are eligible to earn up to an additional 240 well-being incentive credits match when completing certain wellness actions through Sharecare (formerly known as Healthways). Spouses are not eligible for the additional 240 well-being incentive credits match from UnitedHealthcare. This 240 match is in addition to the 480 well-being incentive credits members can earn by completing certain wellness actions through Sharecare.

NOTE: Pharmacy benefits will be administered by CVS Caremark and are subject to the deductible. Benefits are not payable until the deductible is met. The Wellness benefits are administered by Sharecare (formerly known as Healthways).

Health Savings Account (HSA)

A 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 Optum Bank (a subsidiary of UnitedHealthcare), an independent bank, or an independent HSA administrator/custodian.

You can 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, or
3) Medicaid

HSA Features:

- Must be enrolled in a HDHP
- Only the amount of the actual account balance is available for reimbursement
- The employee owns the account and keeps the account
- Investment options are available with a minimum balance and interest accrues on a tax-free basis
- Contributions can start, stop or change anytime
- Distributions cover qualified medical expenses as defined under Section 213(d) of the Internal Revenue Code and certain other expenses
- Tax form 1099 SA and 5498 are sent to employees for filing
- May be used with a general, limited purpose FSA. For more details, please contact your FSA administrator.

NOTE: HSA accounts cannot be combined with a Flexible Spending Account (FSA).

How the Statewide Health Maintenance Organization (HMO) with Blue Cross and Blue Shield of Georgia (BCBSGa) and UnitedHealthcare Works

A HMO allows you to receive covered medical services from in-network providers only (except for emergency care). You are not required to select a Primary Care Physician (PCP) with the statewide HMO. Verify your provider is in-network before selecting a HMO Plan Option. When using in-network providers, request that they use or refer you to other in-network providers. The HMO offers a statewide and national network of providers across the United States.

Plan Features:

- Certain services are subject to a deductible and coinsurance (see the Benefits Comparison Charts)
- You do not have to obtain a referral to see a Specialist (SPC); however, we encourage you to select a PCP to help coordinate your care
- Coverage is only available when using in-network providers (except for emergency care)
- The plan pays 100% of covered services provided by in-network providers that are properly coded as “preventive care” within the meaning of the Affordable Care Act (ACA)
- Co-pays count toward your out-of-pocket maximum
- Co-pays do not count toward your deductible
- The medical and pharmacy out-of-pocket maximums are combined
- Certain drug costs are waived if SHBP is primary and you actively participate in one of the Disease Management (DM) Programs for diabetes, asthma and/or coronary artery disease
- Telemedicine/virtual visits for certain medical services are available, in-network only
- You and your covered spouse are eligible to earn up to 480 well-being incentive credits each by participating in the SHBP well-being program, Be Well SHBP’s administered by Sharecare (formerly known as Healthways)

Members enrolled in UnitedHealthcare are eligible to earn up to an additional 240 well-being incentive credits match when completing certain wellness actions through Sharecare (formerly known as Healthways). Spouses are not eligible for the additional 240 well-being incentive credits match from UnitedHealthcare. This 240 match is in addition to the 480 well-being incentive credits members can earn by completing certain wellness actions through Sharecare.

NOTE: For BCBSGa and UnitedHealthcare, the pharmacy benefits are administered by CVS Caremark and the wellness benefits are administered by Sharecare (formerly known as Healthways).

How the Regional Health Maintenance Organization (HMO) by Kaiser Permanente (KP) Works

The KP Regional HMO Plan Option is available to State Health Benefit Plan (SHBP) eligible members who **live or work** in one of the listed 27 counties within the Metro Atlanta Service Area.

You are responsible for selecting a Primary Care Physician (PCP) from a list of participating providers. You can schedule an appointment without a referral for any specialist at a KP medical facility. You can log onto www.my.kp.org/shbp to select a PCP or call KP Member Services at 855-512-5997.

The KP Regional HMO Plan Option pays 100% of covered services provided by in-network providers that are properly coded as "preventive care" within the meaning of the Affordable Care Act (ACA). KP administers the benefits for medical, pharmacy and wellness.

NOTE: You must live or work in one of the below 27 counties within the Metro Atlanta Service Area to be eligible to enroll in KP:

Barrow	Coweta	Gwinnett	Paulding
Bartow	Dawson	Haralson	Pickens
Butts	DeKalb	Heard	Pike
Carroll	Douglas	Henry	Rockdale
Cherokee	Fayette	Lamar	Spalding
Clayton	Forsyth	Meriwether	Walton
Cobb	Fulton	Newton	

Plan Features:

- This is a co-pay only option
- There are no deductibles or co-insurances
- The medical and pharmacy out-of-pocket maximums are combined
- Telemedicine/virtual visits are available without co-pays
- You and your covered spouse can each earn a $500 Visa gift card for the completion of specific KP wellness activities

Benefits Comparison Charts:

Please read the Benefits Comparison Charts in this guide carefully and look at your medical and prescription expenses to make sure you understand the out-of-pocket costs under each option. In addition, you can find premium rates online at www.shbp.georgia.gov.

Benefits Comparison: HRA Plans

January 1, 2018 – December 31, 2018

	BCBSGa Gold HRA Option		BCBSGa Silver HRA Option		BCBSGa Bronze HRA Option	
	In-Network	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Covered Services	**You Pay**		**You Pay**		**You Pay**	
Deductible • You • You + Spouse • You + Child(ren) • You + Family	$1,500 $2,250 $2,250 $3,000	$3,000 $4,500 $4,500 $6,000	$2,000 $3,000 $3,000 $4,000	$4,000 $6,000 $6,000 $8,000	$2,500 $3,750 $3,750 $5,000	$5,000 $7,500 $7,500 $10,000
	HRA credits will reduce 'You Pay' amounts					
Out-of-Pocket Maximum • You • You + Spouse • You + Child(ren) • You + Family	$4,000 $6,000 $6,000 $8,000	$8,000 $12,000 $12,000 $16,000	$5,000 $7,500 $7,500 $10,000	$10,000 $15,000 $15,000 $20,000	$6,000 $9,000 $9,000 $12,000	$12,000 $18,000 $18,000 $24,000
	HRA credits will reduce 'You Pay' amounts					
HRA	**The Plan Pays**		**The Plan Pays**		**The Plan Pays**	
• You • You + Spouse • You + Child(ren) • You + Family	$400 $600 $600 $800		$200 $300 $300 $400		$100 $150 $150 $200	
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	75% coverage; subject to deductible	60% coverage; subject to deductible
Maternity Care (Non-routine, prenatal, delivery, and postpartum)	85% coverage; subject to deductible	60% coverage; subject to deductible	80% coverage; subject to deductible	60% coverage; subject to deductible	75% coverage; subject to deductible	60% coverage; subject to deductible
Primary Care Physician or Specialist Office or Clinic Visits for the following: • Wellness care/ preventive health care • Prenatal care coded as preventive	100% coverage; not subject to deductible	Not covered	100% coverage; not subject to deductible	Not covered	100% coverage; not subject to deductible	Not covered
Physician Services Furnished in a Hospital • Inpatient Visits; 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	75% coverage; subject to deductible	60% coverage; subject to deductible
Telemedicine/Virtual visit	85% Coverage; not subject to deductible	Not covered	80% Coverage; not subject to deductible	Not covered	75% Coverage; not subject to deductible	Not covered

Benefits Comparison: HMO and HDHP Plans

January 1, 2018 – December 31, 2018

	BCBSGa / UnitedHealthcare Statewide HMO Option	UnitedHealthcare HDHP Option		KP Regional HMO Option
	In-Network only	In-Network	Out-of-Network	In-Network only
Covered Services	**You Pay**	**You Pay**		**You Pay**
Deductible • You • You + Spouse • You + Child(ren) • You + Family	 $1,300 $1,950 $1,950 $2,600	 $3,500 $7,000 $7,000 $7,000	 $7,000 $14,000 $14,000 $14,000	 $0 $0 $0 $0
Out-of-Pocket Maximum • You • You + Spouse • You + Child(ren) • You + Family	 $4,000 $6,500 $6,500 $9,000	 $6,450 $12,900 $12,900 $12,900	 $12,900 $25,800 $25,800 $25,800	 $6,350 $12,700 $12,700 $12,700
HRA	**The Plan Pays**	**The Plan Pays**		**The Plan Pays**
HRA Dollars • You • You + Spouse • You + Child(ren) • You + Family	N/A	N/A		N/A
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	100% coverage after $35 PCP co-pay $45 SPC co-pay	70% coverage; subject to deductible	50% coverage; subject to deductible	100% coverage after $35 PCP co-pay $45 SPC co-pay
Maternity Care (Non-routine, prenatal, delivery and postpartum)	100% coverage after $35 PCP co-pay $45 SPC co-pay	70% coverage; subject to deductible	50% coverage; subject to deductible	100% coverage after $35 PCP co-pay $45 SPC co-pay
Primary Care Physician or Specialist Office or Clinic Visits for the following: • Wellness care/preventive health care • Prenatal care coded as preventive	100% coverage; not subject to deductible, in-network only	100% coverage; not subject to deductible	Not covered	100% coverage
Physician Services Furnished in a Hospital • Inpatient Visits; including charges by surgeon, anesthesiologist, pathologist and radiologist	100% coverage; subject to deductible	70% coverage; subject to deductible	50% coverage; subject to deductible	100% coverage
Telemedicine/Virtual visit	100% coverage after $35 PCP co-pay	70% coverage; subject to deductible	Not covered	100% coverage

Benefits Comparison: HRA Plans

January 1, 2018 – December 31, 2018

	BCBSGa Gold HRA Option		BCBSGa Silver HRA Option		BCBSGa Bronze HRA Option	
	In-Network	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Physicians' Services	**The Plan Pays**		**The Plan Pays**		**The Plan Pays**	
Physician Services for Emergency Care	85% coverage; subject to deductible		80% coverage; subject to deductible		75% 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	75% coverage; subject to deductible	60% coverage; subject to deductible
Outpatient Surgery/ Services • When billed as an office visit	85% coverage; subject to deductible	60% coverage; subject to deductible	80% coverage; subject to deductible	60% coverage; subject to deductible	75% coverage; subject to deductible	60% coverage; subject to deductible
Outpatient Surgery/ Services • When billed as an outpatient surgery at a facility; 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	75% coverage; subject to deductible	60% coverage; subject to deductible
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	75% coverage; subject to deductible	60% coverage; subject to deductible
Inpatient Services • Well newborn care	85% coverage; subject to deductible	60% coverage; subject to deductible	80% coverage; subject to deductible	60% coverage; subject to deductible	75% coverage; subject to deductible	60% coverage; subject to deductible
Outpatient Surgery/ Services • At a hospital or other facility	85% coverage; subject to deductible	60% coverage; subject to deductible	80% coverage; subject to deductible	60% coverage; subject to deductible	75% coverage; subject to deductible	60% coverage; subject to deductible
Hospital Emergency Room Care • Treatment of an emergency medical condition or injury	85% coverage; subject to in-network deductible		80% coverage; subject to in-network deductible		75% coverage; subject to in-network 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	75% coverage; subject to deductible	60% coverage; subject to deductible
Complex Radiology Testing MRIs, CTs, PET and Nuclear Medicine	85% coverage; subject to deductible	60% coverage; subject to deductible	80% coverage; subject to deductible	60% coverage; subject to deductible	75% coverage; subject to deductible	60% coverage; subject to deductible

Benefits Comparison: HMO and HDHP Plans

January 1, 2018 – December 31, 2018

	BCBSGa /UnitedHealthcare Statewide HMO Option	UnitedHealthcare HDHP Option		KP Regional HMO Option
	In-Network only	In-Network	Out-of-Network	In-Network only
Physicians' Services	**The Plan Pays**	**The Plan Pays**		**The Plan Pays**
Physician Services for Emergency Room Care	100% coverage	70% coverage; subject to in-network deductible		100% coverage
Allergy Shots and Serum • When billed as an office visit	100% after $35 PCP co-pay $45 SPC co-pay	70% coverage; subject to deductible	50% coverage; subject to deductible	100% after $35 PCP co-pay $45 SPC co-pay
Outpatient Surgery/Services • When billed as an office visit	100% after $35 PCP co-pay $45 SPC co-pay	70% coverage; subject to deductible	50% coverage; subject to deductible	100% after $35 PCP co-pay $45 SPC co-pay
Outpatient Surgery/Services • When billed as an outpatient surgery at a facility; including charges by surgeon, anesthesiologist, pathologist and radiologist	80% coverage; subject to deductible	70% coverage; subject to deductible	50% coverage; subject to deductible	100% coverage after $100 co-pay
Hospital Services	**The Plan Pays**	**The Plan Pays**		**The Plan Pays**
Inpatient Services • Inpatient care, delivery and inpatient short-term acute rehabilitation services	80% coverage; subject to deductible	70% coverage; subject to deductible	50% coverage; subject to deductible	100% coverage after $250 co-pay
Inpatient Services • Well newborn care	100% coverage; not subject to deductible	70% coverage; subject to deductible	50% coverage; subject to deductible	100% coverage
Outpatient Surgery/Services • At a hospital or other facility	80% coverage; subject to deductible	70% coverage; subject to deductible	50% coverage; subject to deductible	100% coverage after $100 co-pay
Hospital Emergency Room Care • Treatment of an emergency medical condition or injury	100% coverage after $150 co-pay if admitted co-pay waived	70% coverage; subject to in-network deductible		100% coverage after $150 co-pay, if admitted co-pay waived
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	80% coverage; subject to deductible	70% coverage; subject to deductible	50% coverage; subject to deductible	100% coverage at KP or contracted facility $100 co-pay at outpatient hospital facility
Complex Radiology Testing MRIs, CTs, PET and Nuclear Medicine	80% coverage; subject to deductible	70% coverage; subject to deductible	50% coverage; subject to deductible	$45 co-pay at KP or contracted free-standing imaging center $100 co-pay at outpatient hospital facility

Benefits Comparison: HRA Plans

January 1, 2018 – December 31, 2018

	BCBSGa Gold HRA Option		BCBSGa Silver HRA Option		BCBSGa Bronze HRA Option	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Behavioral Health	**The Plan Pays**		**The Plan Pays**		**The Plan Pays**	
Mental Health and Substance Abuse Inpatient Facility and Partial Day Hospitalization **NOTE:** Prior approval required.	85% coverage; subject to deductible	60% coverage; subject to deductible	80% coverage; subject to deductible	60% coverage; subject to deductible	75% coverage; subject to deductible	60% coverage; subject to deductible
Mental Health and Substance Abuse Group Outpatient Visits and Intensive Outpatient	85% coverage; subject to deductible	60% coverage; subject to deductible	80% coverage; subject to deductible	60% coverage; subject to deductible	75% coverage; subject to deductible	60% coverage; subject to deductible
Mental Health and Substance Abuse Outpatient Visits -- Professional	85% coverage; subject to deductible	60% coverage; subject to deductible	80% coverage; subject to deductible	60% coverage; subject to deductible	75% coverage; subject to deductible	60% coverage; subject to deductible
Other Coverage	**The Plan Pays**		**The Plan Pays**		**The Plan Pays**	
Outpatient Acute Short-Term Rehab Services • Physical, Speech and Occupational Therapies • Other Short-Term Rehab Services **NOTE**: There is a benefit maximum of 40 visits (combined in-network and out-of-network) per therapy in a benefit year.	85% coverage; subject to deductible	60% coverage; subject to deductible	80% coverage; subject to deductible	60% coverage; subject to deductible	75% coverage; subject to deductible	60% coverage; subject to deductible
Chiropractic Care Coverage up to a maximum of 20 visits per Plan Year	85% coverage; subject to deductible	60% coverage; subject to deductible	80% coverage; subject to deductible	60% coverage; subject to deductible	75% coverage; subject to deductible	60% coverage; subject to deductible
Vision Routine eye exam Note: Limited to one eye exam every 24 months	100% coverage; not subject to deductible Out-of-network eye exam not covered		100% coverage; not subject to deductible Out-of-network eye exam not covered		100% coverage; not subject to deductible Out-of-network eye exam not covered	
Hearing Services Routine Hearing Exam when properly coded as preventive	100% coverage	Not covered	100% coverage	Not covered	100% coverage	Not Covered
Hearing Services Non-routine hearing not performed in an office setting	85% coverage; subject to deductible	60% coverage; subject to deductible	80% coverage; subject to deductible	60% coverage; subject to deductible	75% coverage; subject to deductible	60% coverage; subject to deductible
Hearing Aid -- Adults Fittings	85% coverage for exam and fittings; subject to deductible $1,500 hearing aid allowance every five years; not subject to deductible		80% coverage for exam and fittings; subject to deductible $1,500 hearing aid allowance every five years; not subject to deductible		75% coverage for exam and fittings; subject to deductible $1,500 hearing aid allowance every five years; not subject to deductible	
Hearing Aid -- Children (Up to age 19) Fittings	85% coverage for exam and fittings; subject to deductible $3,000 hearing aid allowance every four years; not subject to deductible		80% coverage for exam and fittings; subject to deductible $3,000 hearing aid allowance every four years; not subject to deductible		75% coverage for exam and fittings; subject to deductible $3,000 hearing aid allowance every four years; not subject to deductible	

Benefits Comparison: HMO and HDHP Plans

January 1, 2018 – December 31, 2018

	BCBSGa/UnitedHealthcare Statewide HMO Option	UnitedHealthcare HDHP Option		KP Regional HMO Option
	In-Network	In-Network	Out-of-Network	In-Network only
Behavioral Health	**The Plan Pays**	**The Plan Pays**		**The Plan Pays**
Mental Health and Substance Abuse Inpatient Facility and Partial Day Hospitalization **NOTE:** Prior approval required.	80% coverage; subject to deductible	70% coverage; subject to deductible	50% coverage; subject to deductible	100% after $250 co-pay
Mental Health and Substance Abuse Group Outpatient Visits and Intensive Outpatient	100% after $45 SPC per visit. $10 co-pay for group therapy	70% coverage; subject to deductible	50% coverage; subject to deductible	100% after $35 SPC per visit. $17 co-pay for group therapy
Mental Health and Substance Abuse Outpatient Visits -- Professional	100% after $35 PCP co-pay $45 SPC co-pay	70% coverage; subject to deductible	50% coverage; subject to deductible	100% after $35 PCP co-pay $45 SPC co-pay
Other Coverage	**The Plan Pays**	**The Plan Pays**		**The Plan Pays**
Outpatient Acute Short-Term Rehab Services • Physical,Speech and Occupational Therapies • Other Short-Term Rehab Services **NOTE**: There is a benefit maximum of 40 visits (combined in-network and out-of-network) per therapy in a benefit year.	100% after $25 co-pay	70% coverage; subject to deductible	50% coverage; subject to deductible	100% after $25 co-pay
Chiropractic Care Coverage up to a maximum of 20 visits per Plan Year	100% after $45 co-pay	70% coverage; subject to deductible	50% coverage; subject to deductible	100% after $45 co-pay
Vision Routine eye exam Note: Limited to one eye exam every 24 months	100% coverage; not subject to deductible, in-network only	100% coverage; not subject to deductible Out-of-network eye exam not covered		100% coverage; not subject to deductible in-network only
Hearing Services Routine Hearing Exam when properly coded as preventive	100% coverage	100% coverage; not subject to deductible	Not covered	100% coverage
Hearing Services Non-Routine hearing not performed in an office setting	80% coverage; subject to deductible	70% coverage; subject to deductible	50% coverage; subject to deductible	100% after $100 co-pay in outpatient setting or $250 co-pay in inpatient setting
Hearing Aid -- Adults Fittings	100% for exam and fittings; after $35 PCP co-pay $45 SPC co-pay $1,500 hearing aid allowance every five years; not subject to deductible	70% coverage for exam and fittings; subject to deductible $1,500 hearing aid allowance every five years; subject to deductible		100% coverage for exam and fittings $1,500 hearing aid allowance every five years
Hearing Aid -- Children (Up to age 19) Fittings	100% for exam and fittings; after $35 PCP co-pay $45 SPC co-pay $3,000 hearing aid allowance per hearing impaired ear every four years; not subject to deductible	70% coverage for exam and fittings; subject to deductible $3,000 hearing aid allowance per hearing impaired ear every four years; subject to deductible		100% coverage for exam and fittings $3,000 hearing aid allowance per hearing impaired ear every four years

Benefits Comparison: HRA Plans

January 1, 2018 – December 31, 2018

	BCBSGa Gold HRA Option		BCBSGa Silver HRA Option		BCBSGa Bronze HRA Option	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Other Coverage	**The Plan Pays**		**The Plan Pays**		**The Plan Pays**	
Applied Behavior Analysis **NOTE:** Requires prior approval, only covered for treatment for autism spectrum disorders through age 10	85% coverage not subject to deductible $35,000 benefit maximum per Plan Year		80% coverage not subject to deductible $35,000 benefit maximum per Plan Year		75% coverage not subject to deductible $35,000 benefit maximum per Plan Year	
Urgent Care Services	85% coverage; subject to deductible	60% coverage; subject to deductible	80% coverage; subject to deductible	60% coverage; subject to deductible	75% coverage; subject to deductible	60% coverage; subject to deductible
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	75% coverage; subject to deductible	60% coverage; subject to deductible
Skilled Nursing Facility Services **NOTE:** Prior approval required.	85% coverage; up to 120 days per Plan Year; subject to deductible	Not covered	80% coverage; up to 120 days per Plan Year; subject to deductible	Not covered	75% coverage; up to 120 days per Plan Year; subject to deductible	Not covered
Hospice Care **NOTE:** Prior approval required.	85% coverage; subject to deductible	60% coverage; subject to deductible	80% coverage; subject to deductible	60% coverage; subject to deductible	75% coverage; subject to deductible	60% coverage; subject to deductible
Durable Medical Equipment (DME) -- Rental or purchase **NOTE:** Prior approval required for certain DME.	85% coverage; subject to deductible	60% coverage; subject to deductible	80% coverage; subject to deductible	60% coverage; subject to deductible	75% coverage; subject to deductible	60% coverage; subject to deductible
Transplant Services **NOTE:** Prior approval required.	Contact the Medical Claims Administrator for coverage details.					

The Plan may pay a percent of the Maximum Allowable Amount for Covered Services performed by out-of-network providers; the Maximum Allowable Amount is usually 110% of the Medicare rate for the treatment. Deductibles and out-of-pocket maximums are based only on these eligible expenses and do not include amounts you pay when out-of-network providers balance bill for the difference. You cannot use HRA credits to pay for amounts balance billed.

NOTE: *For out-of-network providers, the Plan does not accept assignment of benefits. You will receive a payment of benefits, and it will be your responsibility to pay that to the provider.*

Benefits Comparison: HMO and HDHP Plans

January 1, 2018 – December 31, 2018

	BCBSGa /UnitedHealthcare Statewide HMO Option	UnitedHealthcare HDHP Option		KP Regional HMO Option
	In-Network Only	In-Network	Out-of-Network	In-Network Only
Other Coverage	**The Plan Pays**	**The Plan Pays**		**The Plan Pays**
Applied Behavior Analysis **NOTE:** Requires prior approval, only covered for treatment for autism spectrum disorders though age 10	100% after $35 PCP co-pay $45 SPC co-pay $35,000 benefit maximum per Plan Year	70% coverage; subject to deductible $35,000 benefit maximum per Plan Year		100% after $35 PCP co-pay $45 SPC co-pay $35,000 benefit maximum per Plan Year
Urgent Care Services	100% after $35 co-pay	70% coverage; subject to deductible	50% coverage; subject to deductible	100% after $35 co-pay
Home Health Care Services **NOTE:** Prior approval required	100% coverage	70% coverage; subject to deductible	50% coverage; subject to deductible	100% coverage
Skilled Nursing Facility Services **NOTE:** Prior approval required	100% coverage; up to 120 days per Plan Year; in-network only	70% coverage; up to 120 days per Plan Year; in-network only	Not Covered	100% in-network coverage; Up to 120 days per Plan Year
Hospice Care **NOTE:** Prior approval required	100% coverage	70% coverage; subject to deductible	50% coverage; subject to deductible	100% coverage
Durable Medical Equipment (DME) - Rental or purchase **NOTE:** Prior approval required for certain DME	100% coverage	70% coverage; subject to deductible	50% coverage; subject to deductible	100% coverage
Transplant Services **NOTE:** Prior approval required	Contact the Medical Claim Administrator for coverage details			

The Plan may pay a percent of the Maximum Allowable Amount for Covered Services performed by out-of-network providers; the Maximum Allowable Amount is usually 110% of the Medicare rate for the treatment. Deductibles and out-of-pocket maximums are based only on these eligible expenses and do not include amounts you pay when out-of-network providers balance bill for the difference. You cannot use incentive credits to pay for amounts balance billed.

***NOTE:** For out-of-network providers, the Plan does not accept assignment of benefits. You will receive a payment of benefits and it will be your responsibility to pay that to the provider.*

Benefits Comparison: HRA Pharmacy

January 1, 2018 – December 31, 2018

	Gold HRA Option		Silver HRA Option		Bronze HRA Option	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Other Coverage	**You Pays**		**You Pay**		**You Pay**	
Tier 1 Co-insurance **NOTE**: per 31-day maximum supply	15% ($20 min/$50 max); not subject to deductible		15% ($20 min/$50 max); not subject to deductible		15% ($20 min/$50 max); not subject to deductible	
Tier 2 Co-insurance Preferred Brand **NOTE**: per 31-day maximum supply	25% ($50 min/$80 max); not subject to deductible		25% ($50 min/$80 max); not subject to deductible		25% ($50 min/$80 max); not subject to deductible	
Tier 3 Co-insurance Non-Preferred Brand **NOTE**: per 31-day maximum supply	25% ($80 min/$125 max); not subject to deductible		25% ($80 min/$125 max); not subject to deductible		25% ($80 min/$125 max); not subject to deductible	
Participating 90-day Voluntary Mail Order OR Retail 90-day Network	Tier 1–15% ($50 min/$125 max) Tier 2–25% ($125 min/$200 max) Tier 3–25% ($200 min/$313 max)		Tier 1–15% ($50 min/$125 max) Tier 2–25% ($125 min/$200 max) Tier 3–25% ($200 min/$313 max)		Tier 1–15% ($50 min/$125 max) Tier 2–25% ($125 min/$200 max) Tier 3–25% ($200 min/$313 max)	

NOTE: *Amounts you pay go toward the out-of-pocket maximum.*

NOTE: *If you request a Brand-name Prescription Drug Product in place of the chemically equivalent Prescription Drug Product (Generic equivalent), you will pay the applicable Generic Co-pay in addition to the difference between the Brand and Generic Drug costs. This differential will not apply towards your out-of-pocket maximum.*

NOTE: *CVS Caremark administers the pharmacy benefits for members enrolled in BCBSGa HRA Plan Options.*

Benefits Comparison: HMO and HDHP Pharmacy

January 1, 2018 – December 31, 2018

	BCBSGa/UnitedHealthcare Statewide HMO Option		UnitedHealthcare HDHP Option		KP Regional HMO Option
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network
Other Coverage	**You Pay**		**The Plan Pays**		**You Pay**
Tier 1 Co-insurance **NOTE**: per 31-day maximum supply. KP per 30-day max.	$20 co-pay		*70% coverage; after deductible is met		$20 co-pay
Tier 2 Co-insurance Preferred Brand **NOTE**: per 31-day maximum supply. KP per 30-day max.	$50 co-pay		*70% coverage; after deductible is met		$50 co-pay
Tier 3 Co-insurance Non-Preferred Brand **NOTE**: per 31-day maximum supply. KP per 30-day max.	$90 co-pay		*70% coverage; after deductible is met		$80 co-pay
Participating 90-day Voluntary Mail Order OR Retail 90-day Network	Tier 1–$50 Tier 2–$125 Tier 3–$225 co-pays		*70% coverage; after deductible is met		Tier 1–$50 Tier 2–$125 Tier 3–$200 co-pays

NOTE: *Co-pay amounts you pay do not go toward the deductible; however they do go toward the out-of-pocket maximum.*

***NOTE:** For HDHP out-of-network, pharmacy expenses are paid at 70 percent of the contracted rate after the deductible has been satisfied.*

NOTE: *If you request a Brand-name Prescription Drug Product in place of the chemically equivalent Prescription Drug Product (Generic equivalent), you will pay the applicable Generic co-pay/co-insurance in addition to the difference between the Brand and Generic Drug costs. This differential will not apply towards your out-of-pocket maximum.*

NOTE: *CVS Caremark administers the pharmacy benefits for members enrolled in BCBSGa HMO and UnitedHealthcare HMO and HDHP Plan Options. Kaiser Permanente administers the pharmacy benefits for members enrolled in their Plan Option.*

Alternative Coverage

TRICARE Supplement for Eligible Military Members

Are you career retired military or a reservist? Consider the TRICARE Supplement Plan

The TRICARE Supplement Plan is an alternative to State Health Benefit Plan (SHBP) coverage that is offered to members and dependents who are eligible for SHBP coverage and enrolled in TRICARE. The TRICARE Supplement Plan is not sponsored by the SHBP, the Georgia Department of Community Health (DCH) or any employer. The TRICARE Supplement Plan is sponsored by the Government Employees Association, Inc. (GEA) and is administered by Selman & Company. In general, to be eligible, the members and dependents must each be under age 65, ineligible for Medicare and registered in the Defense Enrollment Eligibility Reporting System (DEERS). If you enroll in the TRICARE Supplement and are not eligible, your election will be changed to the default Plan Option, Blue Cross and Blue Shield of Georgia (BCBSGa) Bronze Health Reimbursement Arrangement (HRA), which includes the Tobacco Surcharge if you were paying for it prior to enrollment in the TRICARE Supplement. For active members, the payroll location will be notified to collect the additional premiums.

Who is eligible for enrollment in the TRICARE Supplement Plan?

Members who are eligible for enrollment in the TRICARE Supplement Plan include the following:

- Military retirees entitled to retired pay and their spouses/surviving spouses who are ineligible for Medicare
- Retired Reservists and National Guardsmen between the ages of 60 and 65 with 20 years of creditable service and their spouses/surviving spouses who are not eligible for Medicare
- Retired Reservists and National Guardsmen under age 60 and enrolled in TRICARE Reserves Select (TRS) and their spouses/surviving spouses who are not eligible for Medicare
- Qualified National Guard and Reserve members
- Military retirees and their spouses/surviving spouses who reside outside the U.S. or its territories (all who are eligible for Medicare must be in Medicare)
- Military retirees and their spouses/surviving spouses age 65 or older but ineligible for Medicare (all must have received a Statement of Disallowance from Social Security Administration)

Points to consider if you elect TRICARE Supplement Plan coverage

- Effective January 1, 2018, 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:
  - Unmarried adult children under the age of 26 who are no longer eligible for regular TRICARE must be enrolled in TRICARE Young Adult (TYA) through TRICARE before enrolling in the TRICARE Supplement Plan
  - Unmarried children under the age of 21 or 23, if a full-time student who are no longer eligible for regular TRICARE, must be enrolled in TYA through TRICARE before enrolling in the TRICARE Supplement Plan
- Tobacco Surcharge 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 Selman & Company, administrator of the TRICARE Supplement
- Loss of eligibility for the TRICARE Supplement Plan is a qualifying event (QE). If you continue to be eligible for coverage under tSHBP, you may enroll in a SHBP option outside of the Open Enrollment period if you make a request within 31 days of losing eligibility for the TRICARE Supplement Plan

- Turning age 65 and becoming eligible for Medicare causes a loss of eligibility for TRICARE Supplement Plan coverage. This is a qualifying event (QE) and retirees must make a request within 31 days to re-enroll in a SHBP coverage option. If no request is made, your election will be changed to the default Plan Option, Blue Cross and Blue Shield of Georgia (BCBSGa) Bronze Health Reimbursement Arrangement (HRA) and/or UnitedHealthcare MA PPO Standard Plan (if applicable)
- 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 make their change on the SHBP Member Portal during the Open Enrollment (OE)

For complete information about eligibility and benefits, call 866-637-9911 or visit www.selmantricareresource.com/ga_shbp. You may also find information at www.shbp.georgia.gov.

2018 Wellness

2018 Wellness for Blue Cross and Blue Shield of Georgia (BCBSGa) and UnitedHealthcare

Healthways is now Sharecare

The State Health Benefit Plan (SHBP) is excited to continue working with our Wellness partner, Sharecare (formerly known as Healthways). If you elect BCBSGa or UnitedHealthcare coverage, you and your covered spouse have access to SHBP's well-being program (administered by Sharecare), called Be Well SHBP. This program offers comprehensive well-being resources and incentives to support your goals for health and well-being. If you want to take big steps toward improved well-being or just a small step in the right direction, Sharecare can help. The program is confidential, voluntary and offered at no additional cost to you.

In 2018, the Sharecare team will provide you with the support, tools, and lifestyle management information you need to improve your health and well-being. The types of support you receive includes: the Sharecare RealAge assessment that determines your body's true age; a highly personalized profile; personalized content to help improve your health habits, earn green days with daily tracking; wellness resources, access to a personal well-being coach; a biometric screening; activities and presentations at your workplace; resources for quitting tobacco; fitness, weight, steps and nutrition challenges; access to recipes, meal plans, trackers, articles and more. To learn more about the many features of the current program, visit the program site at www.BeWellSHBP.com. The enhanced program will launch January 1, 2018.

Participate and Earn Well-Being Incentive Credits

When you participate in SHBP's well-being program (administered by Sharecare), you and your covered spouse are each eligible to earn up to 480 well-being incentive credits to offset eligible medical and pharmacy expenses. The earlier you complete these actions, the earlier you will receive your credits and will be able to start using them. Depending on the Plan Option you select, the well-being incentive credits you will earn work a little differently.

How Well-being Incentive Credits Work With Each Plan Option:				
Plan Option	**BCBSGA HMO**	**BCBSGA HRA**	**UnitedHealthcare HMO**	**UnitedHealthcare HDHP**
Credits deposited by SHBP monthly into your…	MyIncentive Account (MIA)	Health Reimbursement Arrangement (HRA)	Health Incentive Account (HIA) Bonus: UnitedHealthcare matches up to the first 240 well-being incentive credits earned (by employees only) and will automatically add these funds to your HIA.	
How your well-being incentive credits work to offset your out-of-pocket eligible medical and pharmacy out-of-pocket expenses.	When you use your benefits, you pay the provider/pharmacy co-pay upfront as you normally would. Once the claim has been paid, information is sent to the MIA program. If you have MIA credits to cover all, or a portion of the co-pay, co-insurance or deductible, BCBSGa will mail you a reimbursement check (up to the amount of MIA credits available) along with a MIA summary.	When you use your benefits, any funds that are owed to providers/ pharmacies will be automatically paid by BCBSGa out of your HRA first. You will not pay anything until all of your available HRA credits have been used.	When you use your benefits, you pay the provider/pharmacy co-payment upfront. If you have HIA credits to cover all, or a portion of the expense, UnitedHealthcare will automatically send you a reimbursement check (up to the amount of HIA credits available). For any co-insurance or deductible funds owed to providers, if you have enough credits in your HIA to cover all, or a portion of the eligible expense, UnitedHealthcare will automatically mail you a reimbursement check (up to the amount of HIA credits available).	You first pay a portion* of your deductible to activate your ability to use your HIA credits. Once that portion of your deductible has been met, when you use your benefits, any funds owed to providers will be automatically paid by UnitedHealthcare out of your HIA (up to the amount of HIA credits available). For pharmacy, you will pay upfront. If you have enough credits in your HIA to cover all, or a portion of the expense, UnitedHealthcare will automatically mail you a reimbursement check (up to the amount of HIA credits available). *Portion Breakout: You - $1,300 You + Child(ren) - $2,600 You + Spouse - $2,600 You + Family - $2,600

2018 Wellness (cont.)

For members who elect a BCBSGa Health Reimbursement Arrangement (HRA) Plan Option

SHBP will continue to fund base HRA credits to your HRA to provide first-dollar coverage for those covered services requiring a deductible and co-insurance. The HRA credits are used to offset the out-of-pocket amount you must pay. When you complete a health action, well-being incentive credits will be placed into your incentive account within 30 days. After satisfying your deductible, you will pay your co-insurance amount for covered services until you reach your out-of-pocket maximum.

You and/or your covered spouse can earn additional well-being incentive credits for your HRA for the completion of certain health actions. To earn these HRA well-being incentive credits, complete the requirements between January 1 and November 30, 2018.

For members who elect a statewide BCBSGa or UnitedHealthcare Health Maintenance Organization (HMO) Plan Option

You and/or your covered spouse can continue to earn well-being incentive credits into an incentive account for the completion of certain health actions. Incentive accounts house well-being incentive credits tied to the HMO Plan Options. These well-being incentive credits can be used to help you offset certain health care costs such as co-pays, co-insurance and deductibles. When you complete a health action, well-being incentive credits will be placed into your incentive account within 30 days. To earn these credits, complete the requirements between January 1 and November 30, 2018.

For members who elect a UnitedHealthcare High Deductible Health Plan (HDHP) Option

You and/or your covered spouse can continue to earn well-being incentive credits into an incentive account for the completion of certain health actions. Incentive accounts house well-being incentive credits tied to the HDHP Plan Option. These well-being incentive credits can be used to help you offset certain health care costs such as deductibles and co-insurance. When you complete a health action, well-being incentive credits will be placed into your incentive account within 30 days. To earn these credits, complete the requirements between January 1 and November 30, 2018.

NOTE: It is your responsibility to ensure your information is complete and all documentation (including the 2018 Physician Screening Form) is received by Sharecare by November 30, 2018.

IMPORTANT: Before the earned well-being incentive credits in the incentive account can be used, you will need to pay for covered services out of pocket until the following amounts have been paid toward your HDHP deductible:

- You - $1,300
- You + Child(ren) - $2,600
- You + Spouse - $2,600
- You + Family - $2,600

NOTE: The above amounts reflect a portion of the total required HDHP deductible.

Reminder: You and your spouse (if covered) may appeal the well-being incentive credits applied if the credits are less than you believe should have been awarded to you or your covered spouse. Wellness appeals for the 2017 well-being incentive credits must be filed by January 31, 2018. Please see the Summary Plan Description (SPD), for your Plan Option, for additional details.

NOTE: If you terminate your coverage with SHBP, any unused HRA, HIA, or MIA credits will be forfeited.

2018 Wellness (cont.)

If you select BCBSGa or UnitedHealthcare, you and your covered spouse are each eligible to earn up to 480 well-being incentive credits by participating in the SHBP well-being program called Be Well SHBP, administered by Sharecare (formerly known as Healthways). As you earn credits, SHBP will contribute them to your BCBSGa Health Reimbursement Arrangement (HRA) account, BCBSGa MyIncentive Account (MIA) or your UnitedHealthcare Health Incentive Account (HIA) to offset eligible medical and pharmacy expenses.

Wellness – 2018 BCBSGa or UnitedHealthcare Members (non-Medicare Advantage)

Feel better by earning up to 480 well-being incentive credits. These well-being incentive credits will help to offset eligible medical and pharmacy expenses and help you save.

Complete the RealAge Test at www.BeWellSHBP.com and participate in other healthy actions to earn the well-being incentive credits.

Well-being incentive credits will not be awarded until after the completion of the RealAge Test.

For details or questions, go to www.BeWellSHBP.com or call 888-616-6411.

NOTE: All actions must be completed and appropriate documentation (including the 2018 Physician Screening Form) submitted and received by Sharecare between January 1, 2018 and November 30, 2018. It is your responsibility to ensure your information is complete and all documentation (including the 2018 Physician Screening Form) is received by Sharecare by November 30, 2018.

	What to Do	What You will Earn*
1.	**Assess your Health -** Complete the RealAge test A confidential, online questionnaire that will take about 20 minutes to complete.	***Earn 240 well-being incentive credits*** ***Note: Incentive credits cannot be awarded until completion of the RealAge test. Biometrics, Telephonic Coaching and Online Pathways taken before completion of the RealAge Test can only be applied to incentive credits upon RealAge Test completion.***
2.	**Know Your Numbers – Complete a Biometric Screening** (Credits to be awarded after the RealAge Test is completed) You have two options: through your physician using the 2018 Physician Screening Form or at an SHBP-sponsored biometric screening event.	
3.	**Take Action (Credits to be earned after the RealAge Test is completed)** Complete the coaching pathway, online pathway, or a combination of both **Telephonic Coaching Pathway** • Actively engage in telephonic coaching. Earn 60 well-being incentive credits for one completed coaching call per calendar month. You can earn 60 well-being incentive credits up to 4 times, for a maximum of 240 well-being incentive credits **Online Pathway** • Actively track and make progress. Earn 120 well-being incentive credits when you record 60 Green Days within a 90 day period. You can earn 120 well-being incentive credits up to 2 times, for a maximum of 240 well-being incentive credits NOTE: Well-being incentive credits can be earned by logging 8 of 12 Green Day trackers daily within the Sharecare app or on the online platform.	***Earn up to 240 well-being incentive credits*** ***NOTE: You may complete as many coaching calls as you like in a month; however, a maximum of one call in a calendar month qualifies you for the 60 well-being incentive credits.*** ***NOTE: Incentive credits cannot be awarded until completion of the RealAge test. Telephone calls completed or green days earned before completion of the RealAge Test can only be applied to incentive credits upon RealAge Test completion.***

*For details go to www.BeWellSHBP.com or call 888-616-6411.

Rollover Credits: Regardless of what Plan Option you select, all unused well-being incentive credits earned in 2017 will automatically roll over to your 2018 Plan Option (Health Maintenance Organization (HMO), Health Reimbursement Arrangement (HRA) or High Deductible Health Plan (HDHP) and/or vendor (Blue Cross and Blue Shield of Georgia (BCBSGa), UnitedHealthcare and Kaiser Permanente) you choose during Open Enrollment (OE). SHBP will deposit your unused credits in the incentive account associated with your 2018 plan selection in April 2018. If you remain with the same Medical Claims Administrator and in the same Plan Option in which you were enrolled in 2017, rollover credits will be available January 1, 2018.

NOTE: 2018 Wellness Program and incentives administered by Sharecare (formerly known as Healthways) do not apply to Kaiser Permanente. See the Kaiser Permanente Wellness Program description within this guide for details.

2018 Wellness (cont.)

Wellness for Kaiser Permanente (KP)

State Health Benefit Plan (SHBP) is excited to continue to partner with KP. They offer a comprehensive and integrated team approach to wellness. In addition, KP provides a variety of wellness tools and resources and an incentive program designed to empower you to take an active role in your own health. You will have access to KP's tools, activities and services such as the Total Health Assessment, biometric screenings, online and onsite Healthy Living classes. To learn more about the services and programs, visit www.my.kp.org/shbp.

Kaiser Permanente Rollover Account (KPRA)

The KPRA will be available to members enrolling with KP who were previously enrolled in another SHBP Plan Option during 2017 that have unused incentive credits earned in SHBP's Be Well SHBP program administered by Sharecare (formerly known as Healthways). The balance will roll over in April 2018. With the KPRA, members will be able to use those unused credits for eligible medical and pharmacy expenses incurred after April 2018, while insured under the KP Regional HMO plan. If you have questions regarding your KPRA, contact KPRA customer service after April 2018 at 877-761-3399 or visit www.kp.org/healthpayment.

You must first pay your medical co-pay(s) out-of-pocket. Normally, within 15 days of when the claim is processed, you will be reimbursed your co-pay(s) from the available funds in your KPRA. Your KPRA comes with a KP Prescription Drug Card. To maximize your pharmacy benefits, you should use this card at KP pharmacies to pay your co-pay(s) at the point of sale. Although the KP prescription card is accepted outside of the KP network, you will have to pay the full cost of the drug as this is not a covered benefit under your Plan.

NOTE: If you terminate your coverage with SHBP, any unused rollover KPRA credits will be forfeited.

Wellness - 2018 Kaiser Permanente

Earn up to $1,000 and feel the benefits of taking care of your health!

Simply sign-up for the KP Wellness Program at my.kp.org/shbp and make sure you are up-to-date on all four of the activities listed below. Each member (member and covered spouse) who satisfies the KP Wellness Program requirements will receive a $500 Visa gift card ($1,000 per household)! Use your wellness incentive to further embrace your Total Health.

Getting your reward is easy and there is no specific order in which these four wellness activities must be completed! Just sign on to my.kp.org/shbp to accept your Wellness Program agreement, which is required for reward eligibility. For details or questions, go to my.kp.org/shbp or call 866-300-9867.

NOTE: All actions must be completed between January 1, 2018 and November 30, 2018.

	What to Do	What You will Earn
1.	**Take Your Total Health Assessment:** Complete your 2018 KP on-line Total Health Assessment (THA). The questionnaire is confidential and only takes about 20 minutes.	***How will YOU use your $500 Wellness Incentive reward?*** ***Complete all four activities and earn a Visa Gift Card worth $500.*** • Pay for co-pays and prescription medications for the entire year • Relieve stress with quarterly massages • Take a nice weekend hiking trip in the mountains • Splurge on new work-out clothes or walking shoes • Stock up on healthy foods at the grocery store ***Both members and their covered spouses are eligible to earn the incentive for a total of $1000 per household.***
2.	**Know Your Numbers** Complete a Biometric Screening at a Kaiser Permanente Medical Office, or by a KP clinician at an SHBP-sponsored biometric screening event. **NOTE:** ONLY those screenings performed by KP are eligible for the reward.	
3.	**Get Yourself Screened:** Complete all age and gender appropriate preventive screenings for breast, cervical or colorectal cancer.	
4.	**Take an Online Course:** Complete one online Healthy Lifestyle Program (HLP)	

Tobacco Policies

Tobacco Cessation

Every attempt to quit tobacco is worth the effort. It takes planning, support and sometimes, all the will power you've got. But quitting for good is absolutely possible. Both Sharecare (formerly known as Healthways) and KP offer comprehensive online and telephonic tobacco cessation services that provide the tools and support you need to quit successfully. Both programs are confidential, voluntary and are at no additional cost to you. Please go to www.BeWellSHBP.com to learn more for Blue Cross and Blue Shield of Georgia (BCBSGa) and UnitedHealthcare members. For KP members, please go to www.my.kp.org/shbp to learn more.

Tobacco Cessation Medications

Prescription and over-the-counter (OTC) tobacco cessation therapies, including nicotine replacement therapy (NRT), are available. Please go to http://info.caremark.com/shbp to learn more for BCBSGa and UnitedHealthcare members. For KP members, please go to www.my.kp.org/shbp to learn more.

Tobacco Surcharge

Tobacco surcharges are included in all SHBP options (except for the Medicare Advantage Plan Options and TRICARE Supplement). These surcharges are intended to promote tobacco cessation and use of the Tobacco Cessation Online and Telephonic Coaching Programs. Please go to: www.shbp.georgia.gov to access Tobacco Surcharge Removal Requirements policies. These policies allow you to have the tobacco surcharge removed by completing the Tobacco Surcharge Removal Requirements.

Tobacco Surcharge Removal/Refund

In compliance with the Affordable Care Act (ACA) requirements for wellness programs, SHBP's covered tobacco users (members and covered dependents) may qualify for tobacco surcharge refunds or adjustments of premiums paid in 2018 by completing the Tobacco Surcharge Removal Requirements in the Tobacco Users Cessation Policies for BCBSGa, UnitedHealthcare and KP at: www.shbp.georgia.gov.

If You Are Retiring

Planning to retire soon? Here is what you need to know:

- In order to continue your State Health Benefit Plan (SHBP) coverage as a retiree, you and any dependents you want covered must be enrolled in the Plan while you are an active employee immediately prior to your retirement. If you are not enrolled in the SHBP and wish to carry coverage as a retiree, you will need to enroll during Open Enrollment the year prior to your retirement
- If you make a change during Open Enrollment but retire before the change can become effective on January 1, your elections prior to Open Enrollment, including your Plan Option, Tier and covered dependents will remain the same
- If you are retiring and under age 65, and 1) fall under the Annuitant Basic Subsidy Policy, your Plan Options and rates are the same as for active employees and the Tobacco Surcharge question will apply or 2) fall under the Annuitant Years of Service Subsidy Policy, your Plan Options are the same as for active employees but your rates are based on your Years of Service in a State retirement system (e.g., TRS or ERS) and the Tobacco Surcharge question will apply
- If you are retiring and are age 65 or older (or will be turning age 65 at retirement), you have the option of enrolling in a Medicare Advantage with Prescription Drugs (MAPD) Plan Option if you submit your Medicare Part B enrollment information, or remaining in a non-MA Commercial option. Medicare Advantage Plan Options are the only Plan Options subsidized by SHBP for Retirees age 65 and older
- Once retired, you will have a Retiree Option Change Period (ROCP) that will allow you to only change your Plan Option
- You may add dependents only if you have a qualifying event (QE) because Retirees do not have an Open Enrollment Period
- Please refer to the Retiree Decision Guide for additional information regarding your SHBP coverage and options as a retiree
- If you have unused incentive credits of 100 or more in your Health Reimbursement Arrangement (HRA), Health Incentive Account (HIA), MyIncentive Account (MIA) or Kaiser Permanente Rollover Account (KPRA) after being enrolled in a Medicare Advantage (MAPD) Preferred Provider Organization (PPO) option for six months, an individual Retiree Reimbursement Account (RRA) will be set up by your MA vendor. The funds will be available for use after six months of enrolling in MAPD and will be used to reimburse you for eligible medical and pharmacy out-of-pocket expenses to the maximum balance in the RRA

Federal Patient Protection and Affordable Care Act Notices

Choice of Primary Care Physician

The Plan generally allows the designation of a Primary Care Physician/Provider (PCP). You have the right to designate any PCP who participates in the Claims Administrator's network, and who is available to accept you or your family members. For children, you may also designate a pediatrician as the PCP. For information on how to select a PCP, and for a list of participating PCP's, call the telephone number on the back of your Identification Card.

Access to Obstetrical and Gynecological (OB/GYN) Care

You do not need prior authorization from the Plan or from any other person (including a PCP) in order to obtain access to obstetrical or gynecological care from a health care professional in the Claims Administrator's network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, call the telephone number on the back of your Identification Card.

HIPAA Special Enrollment Notice

You do not need prior authorization from the Plan or from any other person (including a PCP) in order to obtain access to obstetrical or gynecological care from a health care professional in the Claims Administrator's network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, call the telephone number on the back of your Identification Card.

Eligible Covered Persons and Dependents may also enroll under two additional circumstances:

- The Covered Person's or Dependent's Medicaid or Children's Health Insurance Program (CHIP) coverage is terminated as a result of loss of eligibility; or
- The Covered Person or Dependent becomes eligible for a subsidy (State Premium Assistance Program).

NOTE: The Covered Person or Dependent must request Special Enrollment within sixty (60) days of the loss of Medicaid/CHIP or of the eligibility determination. To request Special Enrollment or obtain more information, call the SHBP Member Services Center at 1-800-610-1863 or contact your Benefit Coordinator/Payroll Location.

Legal Notices (cont.)

Women's Health and Cancer Rights Act of 1998

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

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

NOTE: Reconstructive surgery requires prior approval, and all Inpatient admissions require prior notification.

For more detailed information on the mastectomy-related benefits available under your Plan option, call the telephone number on the back of your Identification Card.

Newborns' and Mothers' Health Protection Act of 1996

The Plan complies with the Newborns' and Mothers' Health Protection Act of 1996.

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

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT NOTICE OF INFORMATION PRIVACY PRACTICES

Georgia Department of Community Health

State Health Benefit Plan Notice of Information Privacy Practices

Revised July 25, 2017

The purpose of this notice is to describe how medical information about you, which includes your personal information, may be used and disclosed and how you can get access to this information. Please review it carefully.

The Georgia Department of Community Health (DCH) and the State Health Benefit Plan Are Committed to Your Privacy.

DCH understands that your information is personal and private. Certain DCH employees and companies hired by DCH to help administer the Plan (Plan Representatives) use and share your personal and private information in order to administer the Plan. This information is called "Protected Health Information" (PHI), and includes any information that identifies you or information in which there is a reasonable basis to believe can be used to identify you and that relates to your past, present, or future physical or mental health or condition, the provision of health care to you, and payment for those services. This notice tells how your PHI is used and shared by DCH and Plan Representatives. DCH follows the information privacy rules of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA").

Only Summary Information is Used When Developing and/or Modifying the Plan.

The Board of Community Health, which is the governing Board of DCH, the Commissioner of DCH and the Chief of the Plan administer the Plan and make certain decisions about the Plan. During those processes, they may review certain reports that explain costs, problems, and needs of the Plan. These reports never include information that identifies any individual person. If your employer is allowed to leave the Plan entirely, or stop offering the Plan to a portion of its workforce, DCH may provide Summary Health Information (as defined by federal law) for the applicable portion of the workforce. This Summary Health Information may only be used by your employer to obtain health insurance quotes from other sources and make decisions about whether to continue to offer the Plan. Please note that DCH, Plan Representatives, and your employer are prohibited by law from using any PHI that includes genetic information for underwriting purposes.

Legal Notices (cont.)

Plan "Enrollment Information" and "Claims Information" are Used in Order to Administer the Plan. PHI includes two kinds of information, "Enrollment Information" and "Claims Information". "Enrollment Information" includes, but is not limited to, the following types of information regarding your plan enrollment: (1) your name, address, email address, social security number and all information that validates you (and/or your Spouse and Dependents) are eligible or enrolled in the Plan; (2) your Plan enrollment choice; (3) how much you pay for premiums; and (4) other health insurance you may have in effect. There are certain types of "Enrollment Information" which may be supplied to the Plan by you or your personal representative, your employer, other Plan vendors or other governmental agencies that may provide other benefits to you. This "Enrollment Information" is the only kind of PHI your employer is allowed to obtain. Your employer is prohibited by law from using this information for any purpose other than assisting with Plan enrollment.

"Claims Information" includes information your health care providers submit to the Plan. For example, claims information may include medical bills, diagnoses, statements, x-rays or lab test results. It also includes information you may submit or communicate directly to the Plan, such as health questionnaires, biometric screening results, enrollment forms, leave forms, letters and/or telephone calls. Lastly, it includes information about you that may be created by the Plan. For example, it may include payment statements and/or other financial transactions related to your health care providers.

Your PHI is Protected by HIPAA. Under HIPAA, employees of DCH and employees of outside companies and other vendors hired or contracted either directly or indirectly by DCH to administer the Plan are "Plan Representatives," and therefore must protect your PHI. These Plan Representatives may only use PHI and share it as allowed by HIPAA, and pursuant to their "Business Associate" agreements with DCH to ensure compliance with HIPAA and DCH requirements.

DCH Must Ensure the Plan Complies with HIPAA. DCH must make sure the Plan complies with all applicable laws, including HIPAA. DCH and/or the Plan must provide this notice, follow its terms and update it as needed. Under HIPAA, Plan Representatives may only use and share PHI as allowed by law. If there is a breach of your PHI, DCH must notify you of the breach.

Plan Representatives Regularly Use and Share your PHI in Order to Administer the Plan. Plan Representatives may verify your eligibility in order to make payments to your health care providers for services rendered. Certain Plan Representatives may work for contracted companies assisting with the administration of the Plan. By law, these Plan Representative companies also must protect your PHI.

HIPAA allows the Plan to use or disclose PHI for treatment, payment, or health care operations. Below are examples of uses and disclosures for treatment, payment and health care operations by Plan Representative Companies and PHI data sharing.

Claims Administrator Companies: Plan Representatives process all medical and drug claims; communicate with the Plan Members and/or their health care providers.

Wellness Program Administrator Companies: Plan Representatives administer Well-Being programs offered under the Plan; and communicate with the Plan Members and/or their health care providers

Actuarial, Health Care and /or Benefit Consultant Companies: Plan Representatives may have access to PHI in order to conduct financial projections, premium and reserve calculations, and financial impact studies on legislative policy changes affecting the Plan.

State of Georgia Attorney General's Office, Auditing Companies and Outside Law Firms: Plan Representatives may provide legal, accounting and/or auditing assistance to the Plan.

Information Technology Companies: Plan Representatives maintain and manage information systems that contain PHI.

Enrollment Services Companies: Plan Representatives may provide the enrollment website and/or provide customer service to help Plan Members with enrollment matters.

NOTE: Treatment is not provided by the Plan but we may use or disclose PHI in arranging or approving treatment with providers.

Legal Notices (cont.)

Under HIPAA, all employees of DCH must protect PHI and all employees must receive and comply with DCH HIPAA privacy training. Only those DCH employees designated by DCH as Plan Representatives for the SHBP health care component are allowed to use and share your PHI.

DCH and Plan Representatives May Make Uses or Disclosures Permitted by Law in Special Situations. HIPAA includes a list of special situations when the Plan may use or disclose your PHI without your authorization as permitted by law. The Plan must track these uses or disclosures. Below are some examples of special situations where uses or disclosures for PHI data sharing are permitted by law. These include, but are not limited to, the following:

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

Public Health Activities: The Plan may give PHI to other government agencies that perform public health activities.

Information about Eligibility for the Plan and to Improve Plan Administration: The Plan may give PHI to other government agencies, as applicable, that may provide you or your dependents benefits (such as state retirement systems or other state or federal programs) in order to get information about your or your dependent's eligibility for the Plan, to improve administration of the Plan, or to facilitate your receipt of other benefits.

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

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

You May Authorize Other Uses of Your PHI. Plan Representatives may not use or share your PHI for any reason that is not described in this notice without a written authorization by you or your legal representative. For example, use of your PHI for marketing purposes or uses or disclosures that would constitute a sale of PHI are illegal without this written authorization. If you give a written authorization, you may revoke it later.

You Have Privacy Rights Related to Plan Enrollment Information and Claims Information that Identifies You.

Right to Inspect and Obtain a Copy of your Information, Right to Ask for a Correction: You have the right to obtain a copy of your PHI that is used to make decisions about you. If you think it is incorrect or incomplete, you may contact the Plan to request a correction.

Right to Ask for a List of Special Uses and Disclosures: You have the right to ask for a list of all special uses and disclosures.

Right to Ask for a Restriction of Uses and Disclosures or for Special Communications: You have the right to ask for added restrictions on uses and disclosures, but the Plan is not required to agree to a requested restriction, except if the disclosure is for the purpose of carrying out payment or health care operations, is not otherwise required by law, and pertains solely to a health care item or service that you or someone else on your behalf has paid in full. You also may ask the Plan to communicate with you at a different address or by an alternative means of communication in order to protect your safety.

Right to a Paper Copy of this notice and Right to File a Complaint: You have the right to a paper copy of this notice. Please contact the SHBP Member Services Center at 1-800-610-1863 or you may download a copy at www.shbp.georgia.gov. If you think your HIPAA privacy rights may have been violated, you may file a complaint. You may file the complaint with the Plan and/or the U.S. Department of Health & Human Services, Office of Civil Rights, Region IV. You will never be penalized by the Plan or your employer for filing a complaint.

Legal Notices (cont.)

Addresses to File HIPAA Complaints:

Georgia Department of Community Health
SHBP HIPAA Privacy Unit
P.O. Box 1990
Atlanta, GA 30301
1-800-610-1863

U.S. Department of Health & Human Services
Office for Civil Rights
Region IV
Atlanta Federal Center
61 Forsyth Street SW
Suite 3B70
Atlanta, GA 30303-8909
1-877-696-6775

For more information about this Notice, contact:

Georgia Department of Community Health
State Health Benefit Plan
P.O. Box 1990
Atlanta, GA 30301
1-800-610-1863

MENTAL HEALTH PARITY AND ADDICTION EQUITY ACT OPT-OUT NOTICE

Election to be Exempt from Certain Federal law requirements in title XXVII of the Public Health Service Act

Date: July 25, 2017

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

Group health plans sponsored by state and local governmental employers must generally comply with Federal law requirements in title XXVII of the Public Health Service Act. However, these employers are permitted to elect to exempt a plan from the requirements listed below for any part of the plan that is "self-funded" by the employer, rather than provided through a health insurance policy. Your Plan Option is self-funded because the Department of Community Health (DCH) pays all claims directly instead of buying a health insurance policy.

The Department of Community Health has elected to exempt your State Health Benefit Plan from the Mental Health Parity and Addiction Equity Act, that includes protections against having benefits for mental health and substance use disorders be subject to more restrictions than apply to medical and surgical benefits covered by the Plan.

The exemption from these federal requirements will be in effect for the plan year starting January 1, 2018 and ending December 31, 2018. The election may be renewed for subsequent plan years.

Important Notice from State Health Benefit Plan (SHBP)

Centers for Medicare and Medicaid Services (CMS) Medicare Part D Creditable Coverage Notice

Important Notice from the Department of Community Health about Your 2018 Prescription Drug Coverage under the State Health Benefit Plan and Medicare for Plan Year: January 1 – December 31, 2018

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 Department of Community Health has determined that the Prescription Drug coverage offered under SHBP 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 Part D 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 Benefits with the Medicare drug plan coverage the month following receipt of the notice. You should send a copy of your notice to SHBP at: P.O. Box 1990, Atlanta, GA 30301-1990.

IMPORTANT: If you are a retiree and terminate your SHBP coverage, you will not be able to get this SHBP coverage back.

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 sixty-three (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, if you don't join within 63 continuous days after your current coverage ends, 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 Member Services Center at: 1-800-610-1863.

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.

Important Notice from State Health Benefit Plan (SHBP) (cont.)

For More Information about Your Options Under Medicare Prescription Drug Coverage

GEORGIA DEPARTMENT OF COMMUNITY HEALTH

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 at: 1-800-633-4227 (TTY 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 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).

From: January 1, 2018 **To:** December 31, 2018
Date: July 25, 2017

Summaries of Benefits and Coverage

Summaries of benefits and coverage describe each Plan Option in the standard format required by the Affordable Care Act. These documents are posted here: www.shbp.georgia.gov. To request a paper copy, you may call the SHBP Member Services Center 1-800-610-1863.

Georgia Law Section 33-30-13 Notice:

For 2018, some members will experience premium increases. Since some members will experience a premium increase, DCH provides the following notice: "SHBP actuaries have determined that the total cost of coverage (which includes the cost paid by the State and the cost paid by members) under all options is 0% higher than it would be if the Affordable Care Act provisions did not apply."

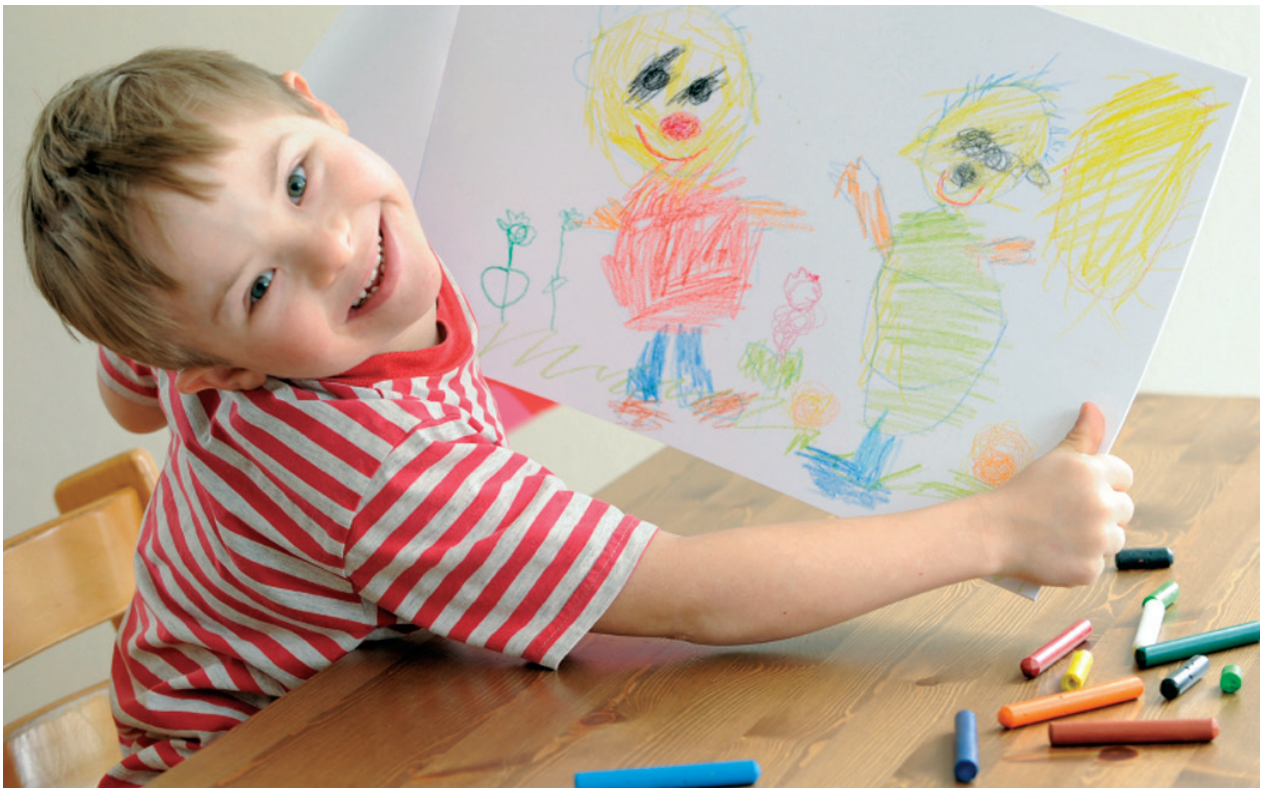
Website for the Annual Open Enrollment (OE) Available

October 16 at 12:00 a.m. through November 3 at 11:59 p.m. ET

For Plan Coverage effective January 1, 2018 – December 31, 2018

The material in this booklet is for information purposes only and is not a contract. It is intended only to highlight principal benefits of the State Health Benefit Plan (SHBP) Plan Options. 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. For all Plan Options other than the Medicare Advantage (MA) options, the Plan Documents including the SHBP regulations, are the Summary Plan Descriptions, Evidence of Coverage documents and reimbursement guidelines of the vendors. The Plan Documents for MA are the Evidence of Coverage (EOC) and the RX Certificate of Coverage. It is the responsibility of each member, active or retired, to read the plan documents to fully understand how that option pays benefits. Availability of SHBP options may change based on federal or state law changes or as approved by the Board of Community Health.

Premiums for SHBP options are established by the DCH Board and may be changed at any time by Board Resolutions subject to advance notice.



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SHBP

State Health Benefit Plan

A Division of the Georgia Department of Community Health