My 2019
SHBP ACTIVE MEMBER DECISION GUIDE
Open Enrollment | October 15 - November 2, 2018
WWW.MYSHBPGA.ADP.COM
<table>
<thead>
<tr>
<th><strong>STATE HEALTH BENEFIT PLAN RESOURCES/CONTACT INFORMATION</strong></th>
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<tr>
<td><strong>MEDICAL CLAIMS ADMINISTRATOR</strong></td>
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<tr>
<td><strong>Anthem Blue Cross and Blue Shield (Anthem)</strong></td>
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<tr>
<td>Member Services: Monday thru Friday, 8:00 a.m. to 8:00 p.m. ET</td>
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<tr>
<td>NurseLine (24 hours a day/7 days per week)</td>
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<tr>
<td>Fraud Hotline</td>
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<tr>
<td><strong>Kaiser Permanente (KP)</strong></td>
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<tr>
<td>Member Services: Monday thru Friday, 7:00 a.m. to 7:00 p.m. ET</td>
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<tr>
<td>Nurse Advice and Appointment Scheduling (24 hours a day/7 days per week)</td>
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<tr>
<td>Prescription Help: Monday thru Friday, 7:00 a.m. to 9:00 p.m. ET, Saturday and Sunday, 9:00 a.m. to 6:00 p.m. ET</td>
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<td>Wellness Program Customer Service: Monday thru Friday (except holidays), 11:00 a.m. to 8:00 p.m. ET</td>
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<tr>
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<td>Kaiser Permanente Rollover Account (KPRA) Customer Service Monday thru Friday (except holidays), 11:00 a.m. to 8:00 p.m. ET</td>
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<td><strong>UnitedHealthcare</strong></td>
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<tr>
<td>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)</td>
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<tr>
<td>Fraud Hotline</td>
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<td><strong>Wellness Program Administrator</strong></td>
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<td><strong>Sharecare</strong></td>
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<tr>
<td>Member Services: Monday thru Friday, 8:00 a.m. to 8:00 p.m. ET</td>
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<td>Corporate Compliance</td>
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<tr>
<td><strong>Pharmacy Administrator</strong></td>
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<tr>
<td><strong>CVS Caremark</strong></td>
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<tr>
<td>Member Services: 24 hours a day/7 days per week</td>
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<tr>
<td>TTY Line</td>
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<tr>
<td>Fraud Hotline</td>
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<td><strong>SHBP</strong></td>
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<td><strong>SHBP Member Services</strong></td>
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<tr>
<td>Open Enrollment: Monday thru Friday, 8:30 a.m. to 7:30 p.m. ET, Saturday, 8:00 a.m. to 5:00 p.m. ET</td>
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<tr>
<td>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</td>
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<td><strong>Additional Information</strong></td>
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<td>Social Security Administration</td>
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<td><strong>Centers for Medicare &amp; Medicaid Services (CMS)</strong></td>
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<td><strong>Centers for Medicare &amp; Medicaid Services (CMS)</strong></td>
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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 and 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.
2018 Open Enrollment for Plan Year 2019

Welcome to the State Health Benefit Plan’s (SHBP) Open Enrollment (OE) for the 2019 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

ANTHEM  Anthem Blue Cross and Blue Shield
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
MAPD  Medicare Advantage with Prescription Drugs
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
Dear State Health Benefit Plan (SHBP) Member:

It is my pleasure as Commissioner of the Department of Community Health (DCH) to welcome you to the 2018 Open Enrollment for Plan Year 2019. SHBP offers our Members two ways to make their elections:

- Online in the SHBP Enrollment Portal at www.mySHBPga.adp.com, from Monday, October 15, 12:00 a.m. ET through Friday, November 2, 2018, 11:59 p.m. ET; or
- By contacting SHBP Member Services at 800-610-1863 during its extended hours for Open Enrollment, Monday - Friday from 8:30 a.m. ET to 7:30 p.m. ET and Saturday, 8:00 a.m. ET to 5:00 p.m. ET.

In 2019, Premiums for Active Members currently employed with State Agencies and Public School Systems will remain the same as in 2018. SHBP will also continue to provide Members with the same high-quality plan designs that we offered in Plan Year 2018, which include the Gold, Silver, and Bronze Health Reimbursement Arrangement (HRA) Plan Options offered by Anthem, the High Deductible Health Plan (HDHP) Plan Option offered by UnitedHealthcare, the statewide Health Maintenance Organization (HMO) Plan Options offered by Anthem and UnitedHealthcare, and the regional HMO Plan Option offered by Kaiser Permanente.

SHBP is also offering additional benefits for our Active Members, which include:

- A new wellness incentive structure offered by Sharecare that will allow Members the option to redeem their incentive points for a $150 Visa Gift Card (to use anywhere Visa is accepted), and
- Mental health benefits in parity with medical benefits, which removes the age limit for ABA therapy, and allows SHBP to cover both Residential Treatment Centers (RTC) and Methadone clinics.

Choosing the right health coverage for you and your covered family members can be overwhelming. I encourage you to use the Decision Support Tools offered in the SHBP Enrollment Portal, to view the Plan Documents on our website at https://shbp.georgia.gov/, and to reach out to SHBP Member Services at 800-610-1863 and directly to Anthem, Kaiser Permanente, and UnitedHealthcare as you consider the various Plan Options.

Thank you for being a valued Member of your SHBP and supporting DCH’s mission to provide Georgians with access to affordable, quality health care through effective planning, purchasing and oversight.

Sincerely,

Frank W. Berry

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Healthcare Facility Regulation | Medical Assistance Plans | State Health Benefit Plan | Office of Health Planning
Equal Opportunity Employer
Welcome to the Georgia Department of Community Health (DCH), State Health Benefit Plan's (SHBP) annual 2018 Open Enrollment for the 2019 Plan Year.

Beginning Monday, October 15, 12:00 a.m. ET through Friday, November 2, 2018, 11:59 p.m. ET., you will have the opportunity to continue your current plan option or enroll in another plan option. Those options will include the same high-quality plan designs that we offered in Plan Year 2018, and the premiums for Active Members employed with State Agencies and Public School Systems will remain the same as they were in Plan Year 2018.

This Active Member Decision Guide is customized for you. It outlines plan options and specific benefit changes that will become effective January 1, 2019 and continue through December 31, 2019. Additionally, you may view the Plan Documents and other helpful information regarding the SHBP on our website at www.shbp.georgia.gov.

On behalf of our Governor, Nathan Deal, Commissioner Frank W. Berry, the Board of Community Health and the entire SHBP family, I encourage you to explore and carefully choose the plan options that meet the needs of you and your family in 2019.

SHBP thanks you for the opportunity to serve you and continue our commitment to offer affordable, quality healthcare for all SHBP members.

Sincerely,

Jeff Rickman
Division Chief, SHBP
Medical Claims Administrators

Anthem Blue Cross and Blue Shield (Anthem), Kaiser Permanente (KP) and UnitedHealthcare will continue to offer State Health Benefit Plan (SHBP) members the Commercial Plan Options listed below for 2019.

Plan Option Offerings

Health Maintenance Organization (HMO)
- Anthem
- KP (Metro Atlanta Service Area In-Network only plan)
- UnitedHealthcare

High Deductible Health Plan (HDHP) with an option to open a HSA
- UnitedHealthcare

Health Reimbursement Arrangement (HRA) without co-pays
- Anthem: Gold, Silver and Bronze
# Wellness Incentives

## At-a-Glance

![Image: WELLNESS INCENTIVES AT-A-GLANCE]

### 2019 Wellness Incentives At-a-Glance

<table>
<thead>
<tr>
<th>Plan Option</th>
<th>Anthem HMO MynIncentive Account (MIA)</th>
<th>Anthem Health Reimbursement Arrangement (HRA)</th>
<th>Kaiser Permanente (KP) Regional HMO</th>
<th>UnitedHealthcare HMO Health Incentive Account (HIA)</th>
<th>UnitedHealthcare HDHP Health Incentive Account (HIA)</th>
</tr>
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<tbody>
<tr>
<td>Who’s Eligible</td>
<td>Up to</td>
<td>Up to</td>
<td>Up to</td>
<td>Up to</td>
<td>Up to</td>
</tr>
<tr>
<td>Member</td>
<td>480</td>
<td>480</td>
<td>$500*</td>
<td>480</td>
<td>480</td>
</tr>
<tr>
<td>Spouse</td>
<td>480</td>
<td>480</td>
<td>$500*</td>
<td>480</td>
<td>480</td>
</tr>
<tr>
<td>Bonus credits for member and spouse**</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
<td>480**</td>
<td>480**</td>
</tr>
<tr>
<td>Potential Total</td>
<td>960</td>
<td>960</td>
<td>$1,000*</td>
<td>1,440</td>
<td>1,440</td>
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</table>

**Anthem:** members enrolled in an Anthem HRA Plan Option 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.

**KP:** members enrolled in the KP Regional HMO Plan Option and their covered spouses will each receive a $500 Mastercard reward card after they each satisfy KP’s Wellness Program requirements.

**UnitedHealthcare:** New for 2019! Spouses enrolled in an UnitedHealthcare Plan Option can now earn a 240 well-being incentive credit match. This means Members and their covered spouses enrolled in an UnitedHealthcare Plan Option can each earn a 240 well-being incentive credit match with a maximum combined up to 480 well-being incentive credits matched by UnitedHealthcare for completing wellness requirements under the plan. After credits are added to your HIA, any remaining credits will rollover each plan year.
**What’s New in 2019**

**New Wellness Incentive Structure for Anthem Blue Cross and Blue Shield and UnitedHealthcare Commercial Plan Options**

Members enrolled in Anthem Blue Cross and Blue Shield (Anthem) and UnitedHealthcare Commercial Plan Options can earn 480 well-being incentive points and choose to redeem them for either:

1. A $150 Visa Gift Card (to use anywhere Visa is accepted); or
2. 480 well-being incentive credits (to apply toward eligible medical or pharmacy expenses)

See 2019 Wellness section for details.

**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. 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.

**Methadone Clinics and Residential Treatment**

New in 2019, Mental Health Benefits will be expanded to include coverage for Methadone Clinics and Residential Treatment Centers. Prior approval through your elected Medical Claims Administrator (Anthem, Kaiser Permanente, or UnitedHealthcare) will be required.

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**Important Plan Reminders**

**New Identification Cards**

All Anthem, UnitedHealthcare and new Kaiser Permanente Members will receive new identification cards before January 1st. Due to mailing restrictions, Members may receive cards at different times.

**Social Security Number (SSN) or other Taxpayer Identification Number (TIN)**

All members must provide SHBP with their Taxpayer Identification Number (TIN) for themselves and their enrolled dependents upon enrolling in SHBP coverage. 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.

The requirement to provide a SSN or other TIN is a separate process from Dependent Verification. Dependents whose coverage is terminated due to providing an invalid SSN or no SSN are not eligible for coverage even if they passed the Dependent Verification process as they have failed to provide a valid SSN to SHBP.

Members should provide their dependent’s SSN by entering it directly into the SHBP Enrollment Portal at https://myshbpga.adp.com/shbp/ or by calling SHBP Member Services at 800-610-1863.

**Dependent Verification**

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. If you elect to cover dependents, generally, they will be placed in a pending status until: 1) the required documentation is submitted within 45 days of the QE proving they are eligible for coverage, or 2) until the deadline to provide the documentation has passed, whichever occurs first.
Important Plan Reminders (continued)

There’s Still Time to Earn 2018 Well-Being Incentive Credits

**Anthem Blue Cross and Blue Shield (Anthem) and UnitedHealthcare Commercial Plan Options:** Members and their covered spouses currently enrolled in Anthem and UnitedHealthcare Commercial Plan Options who have not completed the required health actions or have not taken any actions have until November 30, 2018 to:

- Complete all required actions, and
- Submit the 2018 Physician Screening Form to earn the 2018 well-being incentive credits.

If you have questions or need help getting started, visit [www.BeWellSHBP.com](http://www.BeWellSHBP.com) or contact Sharecare at 888-616-6411.

**Kaiser Permanente:** Members and their covered spouses currently enrolled in the KP Regional HMO Plan Option have until November 30, 2018 to complete all four wellness activities to receive a $500 Mastercard reward card. Visit KP’s website at [www.my.kp.org/shbp](http://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.

**2018 Rollover Credits:** Regardless of what Plan Option you select, all unused well-being incentive credits earned in 2018 will automatically roll over to your 2019 Plan Option you choose during Open Enrollment. SHBP will deposit your unused credits in the incentive account associated with your 2019 plan selection in April 2019. If you remain with the same Medical Claims Administrator and in the same Plan Option in which you were enrolled in 2018, rollover credits will be available January 1, 2019.

**Telemedicine/Virtual Visits**

Telemedicine/virtual visits is a benefit that is available to SHBP members under all Plan Options. Telemedicine allows healthcare 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.

**Summary of Benefits and Coverage (SBC) for Commercial Plan Options**

SHBP provides Summary of Benefits and Coverage (SBC) for the following Commercial Plan Options: Health Maintenance Organization (HMO), Health Reimbursement Arrangement (HRA) and High Deductible Health Plan (HDHP). SBCs include standard information that help you to understand, evaluate and compare the Plan Options as you make decisions about which Plan Option to choose.

The SBCs are available online at [www.shbp.georgia.gov](http://www.shbp.georgia.gov) and you may request a paper copy of the SBCs free of charge by calling SHBP Member Services at 800-610-1863.
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 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 well-being incentive balances are not prorated nor transferrable. For additional information, please reference the Eligibility & Enrollment Provisions at [www.shbp.georgia.gov](http://www.shbp.georgia.gov).
The State Health Benefit Plan (SHBP) has two subsidy policies that determine the amount of subsidy Annuitants (Retirees) will receive from the 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 2019 Plan Year. For questions regarding the New Policy, please contact 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.
Open Enrollment (OE) and Your Responsibilities

SHBP Enrollment Portal for OE available from October 15 at 12:00 a.m. through November 2, 2018 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 2, 2018 by 11:59 p.m. ET
- Read and make sure you understand the plan materials posted at www.shbp.georgia.gov 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 your HR department
- Update any changes in contact information (i.e., address, email, phone number) by notifying your 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)
- Provide your Medicare Part B information to SHBP at least one month prior to your retirement if you and/or your covered dependent, as applicable, are age 65 or older. Note: Failure to do so will result in you and/or your covered dependent(s) remaining enrolled in a SHBP Commercial (Non-Medicare Advantage) Plan Option and you will pay 100% of the unsubsidized premium, which is substantially higher than the SHBP Medicare Advantage Plan Options.

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 2019 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 (exchange) is NOT a QE
Making Your Health Benefit Election for 2019

Open Enrollment (OE) begins October 15, 2018, 12:00 a.m. ET and ends November 2, 2018, 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, if applicable. Due to expected heavy call volume and online traffic, we strongly encourage all members to: 1) confirm your access to the enrollment portal in advance of the Open Enrollment (OE) election start date, and 2) make your election early.

Unable to Make Elections Online or Need Technical Assistance?
If you are unable to make your election(s) online or need technical assistance, please call SHBP Member Services at 800-610-1863 prior to the last day of OE.

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 website, or by contacting SHBP Member Services, you have made a decision to take the default coverage below:

- **Currently Enrolled in a SHBP Commercial Plan Option in 2018:** If you are enrolled in a Commercial Plan Option in 2018, you will remain in your current Plan Option and tier with your current Medical Claims Administrator in 2019.

- **Currently Enrolled in TRICARE Supplement in 2018:** If you are enrolled in the TRICARE Supplement in 2018, you will remain enrolled in the TRICARE Supplement for 2019.

NOTE: If you paid a Tobacco Surcharge in 2018, it will continue to apply. If you did not pay a Tobacco Surcharge in 2018, you will not pay one if you default coverage. Remember, it is your responsibility to notify SHBP immediately if you and/or your covered dependent(s) no longer qualify for the Tobacco Surcharge. Also, it is your responsibility to contact SHBP if you and/or your covered dependent(s) resumes his/her tobacco use. You must notify SHBP if your answer to the Tobacco Surcharge question changes.

How to Make Your 2019 Health Benefit Election
Go to the SHBP Enrollment Portal: www.mySHBPga.adp.com

Step 1: Log on to the SHBP 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 2019 election. If you are a returning user but have not accessed the website since 9/15/18 then you must first reset your password before making your 2019 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 2019 Plan Year.
Step 2: Under the Open Enrollment window, click on Continue to proceed with your 2019 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 (if applicable). Verify that each dependent has a valid Social Security number (SSN) or other Taxpayer Identification Number (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 radio option.

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 (i.e., Decision Support 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 additional information on this page 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 radio option 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 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” will display on the screen and show the elections you made. You should carefully review your elections.

Step 11: Click Finish.

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.

NOTE: The Medicare Advantage Plan Options and TRICARE Supplement are not supported by Decision Support Tools.

Newly added dependents, generally, will be placed in a pending status until: 1) the required documentation is submitted within 45 days of your election proving they are eligible for coverage, or 2) until the deadline to provide the documentation has passed, whichever occurs first.

Open Enrollment (OE) Checklist

- Verify all desired dependents are listed on the Confirmation Page and have a valid Social Security Number (SSN) or other Tax Identification Number (TIN)
- Verify your coverage tier (you only, you + spouse, you + child(ren) or you + family)
- Confirm that 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 2019 unless you experience a Qualifying Event (QE) that allows you to make a change.
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 2018 Open Enrollment (OE) will be the coverage you have for the entire 2019 Plan Year, unless you have a Qualifying Event (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 the Eligibility & Enrollment Provisions document available online at www.shbp.georgia.gov.

You may also contact SHBP Member Services for assistance at 800-610-1863.

How to Declare a Qualifying Event (QE)

To declare a Qualifying Event, you must log on to the SHBP Enrollment Portal at www.mySHBPga.adp.com or contact SHBP Member Services at 800-610-1863.

Note: You can declare a Qualifying Event (QE) in the SHBP Enrollment Portal on the day of, but no earlier than, the date on which the event actually occurs. For example, if your spouse loses his/her coverage with his/her current employer on November 29, 2018, you cannot declare the QE in the Enrollment Portal until November 29, 2018 (i.e., date of the event). If you do not declare the QE in the Enrollment Portal within 31 days of November 29, 2018 (i.e., date of the event), you will not be able to make your QE in the Enrollment Portal on a later date. When entering the QE in the portal, you must ensure that you enter the correct date of the event as this calculates the effective date of the change resulting from the QE. You may also call SHBP Member Services within the 31 days of the QE and the representatives will make the necessary changes for you.

If you elect to cover dependents, generally, they will be placed in a pending status until: 1) the required documentation is submitted within 45 days of the QE proving they are eligible for coverage, or 2) until the deadline to provide the documentation has passed, whichever occurs first.

QEs include, but are not limited to:
- Birth, adoption of a child, or child due to legal guardianship
- 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 discontinuation of coverage/ non-compliance/ failure to make payment)

Eligible Dependents*

State Health Benefit Plan (SHBP) covers eligible dependents who meet SHBP guidelines. Eligible dependents include:
- Spouse
- Dependent Child
  - Natural child
  - Adopted child
  - Stepchild
- Child due to Guardianship


Flexible Benefits Program

SHBP does not provide Flexible Benefits (e.g., dental, vision). If you are eligible to make flexible benefit elections through your Employer, please contact your HR Department, or under the Flexible Benefits Program administered by the Department of Administration Services (DOAS), please visit www.GABreeze.ga.gov or call 877-342-7339.
If you are having a baby, you MUST add your newborn child and submit the social security number (SSN) or other tax identification number (TIN) within 90 days of the birth in order for the baby to be covered as a dependent by SHBP. You may also have to change Plan Tiers. For additional information, please see SHBP’s Eligibility & Enrollment Provisions document available online at www.shbp.georgia.gov.
New Hires

Effective Date of Coverage

The effective date of coverage for new hires is the first of the month following one full calendar month of employment with an SHBP Employing Entity (e.g., State Agencies and Public School Systems), unless the hire date is concurrent with the first day of the month. If the hire date is concurrent with the first day of the month, then coverage is effective the first day of the month following the hire date.*

Examples:

- If hired October 15, 2018, one full calendar month following October is November 1, 2018 – November 30, 2018, and coverage would begin the first day of the month following November, which would be December 1, 2018
- If hired November 1, 2018, since the hire date is concurrent with the first day of the month, coverage would begin the first day of the following month, which would be December 1, 2018
- If hired January 31, 2019, one full calendar month following January is February 1, 2019 – February 28, 2019, and coverage would begin the first day of the month following February, which would be March 1, 2019

New Hires Must Make their Election Directly with SHBP

SHBP requires that new hires make their elections directly in the SHBP Enrollment Portal at www.mySHBPga.adp.com or by contacting SHBP Member Services at 800-610-1863. Making your election with your employer or through any other process does not satisfy this requirement. If you fail to enroll in SHBP coverage as a new hire, your next opportunity to enroll in SHBP coverage will be during the next Open Enrollment period, unless you have a Qualifying Event that allows a change to your coverage.

For more information on how to make your election, please see the section: Making Your Health Benefit Election for 2019.

Rehires and Transfers

Rehires and Transfers with a break in SHBP coverage of 30 days or less are not considered new hires. Therefore, they will retain the same coverage or waiver of coverage status prior to the rehire or transfer occurring.

*Note: If the first day of the month falls on a weekend or holiday, the next business day is considered the first day of the month for SHBP purposes.
SHBP Members may elect a Commercial Plan Option which includes the following:

**Anthem Blue Cross and Blue Shield (Anthem)**

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

**UnitedHealthcare**

- High Deductible Health Plan (HDHP) with an option to open a HSA
- Statewide Health Maintenance Organization (HMO)

**Kaiser Permanente (KP)**

The KP Regional HMO (Metro Atlanta Service Area only) offers medical, wellness and pharmacy benefits. 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
- Bartow
- Butts
- Carroll
- Cherokee
- Clayton
- Cobb
- Coweta
- Dawson
- DeKalb
- Douglas
- Fayette
- Forsyth
- Fulton
- Gwinnett
- Haralson
- Heard
- Henry
- Lamar
- Meriwether
- Newton
- Paulding
- Pickens
- Pike
- Rockdale
- Spalding
- Walton

**Additional Option**

The TRICARE Supplement will continue to be available for those members enrolled in TRICARE. See “Alternative Coverage” section for additional information.

**CVS Caremark**

Administers the pharmacy benefits for members who enroll in Anthem and UnitedHealthcare Commercial Plan Options. CVS Caremark will provide benefits for retail prescription drug products, mail order, home delivery and specialty pharmacy service.

**NOTE:** Members do not have to go to a CVS pharmacy location for their prescriptions. CVS Caremark has a broad pharmacy network. Use CVS Caremark’s pharmacy locator tool to find a network pharmacy near you.

[https://info.caremark.com/shbp](https://info.caremark.com/shbp)

**Sharecare**

Provides comprehensive well-being resources and incentive programs for members who enroll in Anthem and UnitedHealthcare Commercial Plan Options. Sharecare will also administer the 2019 action based health incentives that will allow these SHBP members and their covered spouses to earn additional well-being incentives.
Understanding Your Plan Options
For 2019

How the Health Reimbursement Arrangement (HRA) with Anthem Blue Cross and Blue Shield (Anthem) 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 are enrolled. If you have unused credits in your HRA account from 2018, those credits will roll over to the next Plan Year as long as you remain enrolled in a SHBP Plan Option, excluding TRICARE Supplement. If you were previously a member of another SHBP Plan Option, all unused 2018 well-being incentive credits will roll over to your 2019 HRA plan, or any other Plan Option, in April 2019.

**NOTE:** There is a date limitation to how the 2018 rollover credits can be used for reimbursement. Only eligible medical and pharmacy expenses incurred after the rollover in April 2019 will qualify for reimbursement using the 2018 rollover credits. Eligible medical and pharmacy expenses incurred between January and March 2019 are not eligible for reimbursement using 2018 rollover credits, unless you elect to remain in an HRA. If you stay in an HRA, rollover credits will be available January 1, 2019. However, until your unused 2018 credits roll over, your 2019 HRA credits funded by SHBP and any well-being incentive credits earned in 2019 (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 deductible and your out-of-pocket maximums
- 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 the 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
How the High Deductible Health Plan (HDHP) with UnitedHealthcare Works

The HDHP offers in-network and out-of-network benefits and provides access to one of the largest network of providers statewide and on a national basis across the United States. In addition to the HDHP’s low monthly premium, an important benefit of the HDHP is you are able to open a Health Savings Account (HSA) that allows you to save money tax deferred to help offset your plan costs.

Members and their covered spouses enrolled in an UnitedHealthcare Plan Option can each earn a 240 well-being incentive credit match with a maximum combined up to 480 well-being incentive credits matched by UnitedHealthcare for completing wellness requirements under the plan.

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 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 in-network deductible of $3,500 and a maximum individual in-network out-of-pocket of $6,450. The individual out-of-network deductible maximum 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.

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 ($1,350 individual; $2,700 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 ($1,350 individual; $2,700 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

Health Savings Account (HSA)

An HSA is like a personal savings account with investment options for health care, except it’s all tax-free. You may open an HSA with Optum Bank (a subsidiary of UnitedHealthcare), an independent bank, or an independent HSA administrator/custodian.

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

You can open an HSA if you enroll in the State Health Benefit Plan (SHBP) High Deductible Health Plan (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 an HDHP
- The HSA cannot be used with a FSA*
- Only the amount of the actual account balance is available for reimbursement
- The employee owns the account and keeps the account
- Balances rollover each plan year
- 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.
How the Statewide Health Maintenance Organization (HMO) with Anthem Blue Cross and Blue Shield (Anthem) and UnitedHealthcare Works

An 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 an 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.

Members and their covered spouses enrolled in an UnitedHealthcare Plan Option can each earn a 240 well-being incentive credit match with a maximum combined up to 480 well-being incentive credits matched by UnitedHealthcare for completing wellness requirements under the plan.

Plan Features:

- There are co-pays with this plan for certain services
- Certain services are subject to a deductible and co-insurance (see the Benefits Comparison Chart)
- 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 Programs (DM) for diabetes, asthma, and/or coronary artery disease
- Telemedicine/virtual visits are available, in-network only
How the Regional Health Maintenance Organization (HMO) with Kaiser Permanente (KP) Works

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

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

Plan Features:

- This is a co-pay only option
- There are no deductibles or co-insurance
- 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 Mastercard reward card for the completion of specific KP wellness activities
Benefits Comparison:
SHBP Commercial Plan Options

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, 2019 - December 31, 2019**

<table>
<thead>
<tr>
<th>Covered Services</th>
<th>In-Network</th>
<th>Out-of-Network</th>
<th>In-Network</th>
<th>Out-of-Network</th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Deductible</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>You</td>
<td>$1,500</td>
<td>$3,000</td>
<td>$2,000</td>
<td>$4,000</td>
<td>$2,500</td>
<td>$5,000</td>
</tr>
<tr>
<td>You + Spouse</td>
<td>$2,250</td>
<td>$4,500</td>
<td>$3,000</td>
<td>$6,000</td>
<td>$3,750</td>
<td>$7,500</td>
</tr>
<tr>
<td>You + Child(ren)</td>
<td>$2,250</td>
<td>$4,500</td>
<td>$3,000</td>
<td>$6,000</td>
<td>$3,750</td>
<td>$7,500</td>
</tr>
<tr>
<td>You + Family</td>
<td>$3,000</td>
<td>$6,000</td>
<td>$4,000</td>
<td>$8,000</td>
<td>$5,000</td>
<td>$10,000</td>
</tr>
<tr>
<td><strong>Out-of-Pocket Maximum</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>You</td>
<td>$4,000</td>
<td>$8,000</td>
<td>$5,000</td>
<td>$10,000</td>
<td>$6,000</td>
<td>$12,000</td>
</tr>
<tr>
<td>You + Spouse</td>
<td>$6,000</td>
<td>$12,000</td>
<td>$7,500</td>
<td>$15,000</td>
<td>$9,000</td>
<td>$18,000</td>
</tr>
<tr>
<td>You + Child(ren)</td>
<td>$6,000</td>
<td>$12,000</td>
<td>$7,500</td>
<td>$15,000</td>
<td>$9,000</td>
<td>$18,000</td>
</tr>
<tr>
<td>You + Family</td>
<td>$8,000</td>
<td>$16,000</td>
<td>$10,000</td>
<td>$20,000</td>
<td>$12,000</td>
<td>$24,000</td>
</tr>
</tbody>
</table>

HRA credits will reduce ‘You Pay’ amounts

<table>
<thead>
<tr>
<th>HRA Services</th>
<th>The Plan Pays</th>
<th>The Plan Pays</th>
<th>The Plan Pays</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary Care Physician or Specialist Office or Clinic Visits</td>
<td>85% coverage; subject to deductible</td>
<td>60% coverage; subject to deductible</td>
<td>85% coverage; subject to deductible</td>
</tr>
<tr>
<td>Treatment of illness or injury</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Maternity Care (Non-routine, prenatal, delivery, and postpartum)</td>
<td>85% coverage; subject to deductible</td>
<td>60% coverage; subject to deductible</td>
<td>85% coverage; subject to deductible</td>
</tr>
<tr>
<td>Primary Care Physician or Specialist Office or Clinic Visits for the following:</td>
<td>100% coverage; not subject to deductible</td>
<td>Not covered</td>
<td>100% coverage; not subject to deductible</td>
</tr>
<tr>
<td>Wellness care/preventive health care</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prenatal care coded as preventive</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physician Services Furnished in a Hospital</td>
<td>85% coverage; subject to deductible</td>
<td>60% coverage; subject to deductible</td>
<td>85% coverage; subject to deductible</td>
</tr>
<tr>
<td>Inpatient Visits; including charges by surgeon, anesthesiologist, pathologist and radiologist</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Telemicine/Virtual visit</td>
<td>85% coverage; not subject to deductible</td>
<td>Not covered</td>
<td>80% coverage; not subject to deductible</td>
</tr>
</tbody>
</table>

HRA credits will reduce ‘You Pay’ amounts

<table>
<thead>
<tr>
<th>HRA Services</th>
<th>The Plan Pays</th>
<th>The Plan Pays</th>
<th>The Plan Pays</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physicians’ Services</td>
<td>The Plan Pays</td>
<td>The Plan Pays</td>
<td>The Plan Pays</td>
</tr>
<tr>
<td></td>
<td>$400</td>
<td>$200</td>
<td>$100</td>
</tr>
<tr>
<td></td>
<td>$600</td>
<td>$300</td>
<td>$150</td>
</tr>
<tr>
<td></td>
<td>$600</td>
<td>$300</td>
<td>$150</td>
</tr>
<tr>
<td></td>
<td>$800</td>
<td>$400</td>
<td>$200</td>
</tr>
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</table>
### Benefits Comparison: HMO and HDHP Plans

**January 1, 2019 - December 31, 2019**

<table>
<thead>
<tr>
<th>Covered Services</th>
<th>Anthem / UnitedHealthcare Statewide HMO Option</th>
<th>UnitedHealthcare HDHP Option</th>
<th>KP Regional HMO Option</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Deductible</strong></td>
<td><strong>You</strong></td>
<td><strong>You</strong></td>
<td><strong>You</strong></td>
</tr>
<tr>
<td>• You</td>
<td>$1,300</td>
<td>$3,500</td>
<td>$7,000</td>
</tr>
<tr>
<td>• You + Spouse</td>
<td>$1,950</td>
<td>$7,000</td>
<td>$14,000</td>
</tr>
<tr>
<td>• You + Child(ren)</td>
<td>$1,950</td>
<td>$7,000</td>
<td>$14,000</td>
</tr>
<tr>
<td>• You + Family</td>
<td>$2,600</td>
<td>$7,000</td>
<td>$14,000</td>
</tr>
<tr>
<td><strong>Out-of-Pocket Maximum</strong></td>
<td><strong>You</strong></td>
<td><strong>You</strong></td>
<td><strong>You</strong></td>
</tr>
<tr>
<td>• You</td>
<td>$4,000</td>
<td>$6,450</td>
<td>$12,900</td>
</tr>
<tr>
<td>• You + Spouse</td>
<td>$6,500</td>
<td>$12,900</td>
<td>$25,800</td>
</tr>
<tr>
<td>• You + Child(ren)</td>
<td>$6,500</td>
<td>$12,900</td>
<td>$25,800</td>
</tr>
<tr>
<td>• You + Family</td>
<td>$9,000</td>
<td>$12,900</td>
<td>$25,800</td>
</tr>
</tbody>
</table>

| HRA                                                   | **The Plan Pays**                            | **The Plan Pays**            | **The Plan Pays**      |
|                                                      | **You**                                       | **You**                     | **You**                |
| • You                                                  | N/A                                           | N/A                          | N/A                    |
| • You + Spouse                                         | N/A                                           | N/A                          | N/A                    |
| • You + Child(ren)                                     | N/A                                           | N/A                          | N/A                    |
| • You + Family                                         | N/A                                           | N/A                          | N/A                    |

| Physicians’ Services                                   | **The Plan Pays**                            | **The Plan Pays**            | **The Plan Pays**      |
|                                                      | **The Plan Pays**                            | **The Plan Pays**            | **The Plan Pays**      |
| Primary Care Physician or Specialist Office or Clinic Visits | 100% coverage after $35 PCP co-pay, subject to deductible | 70% coverage; subject to deductible | 50% coverage; subject to deductible |
| Treatment of illness or injury                         | $45 SPC co-pay                               | $45 SPC co-pay               | $45 SPC co-pay         |
| Maternity Care (Non-routine, prenatal, delivery, and postpartum) | 100% coverage after $35 PCP co-pay, subject to deductible | 70% coverage; subject to deductible | 50% coverage; subject to deductible |
|                                                      | $45 SPC co-pay                               | $45 SPC co-pay               | $45 SPC co-pay         |
| Primary Care Physician or Specialist Office or Clinic Visits for the following: Wellness care/preventive health care | 100% coverage; not subject to deductible, in-network only | 100% coverage; not subject to deductible | Not covered |
| • Prenatal care coded as preventive                    |                                              |                              |                        |
| Physician Services Furnished in a Hospital             | 100% coverage after $35 PCP co-pay, subject to deductible | 70% coverage; subject to deductible | 50% coverage; subject to deductible |
| • Inpatient Visits; including charges by surgeon, anesthesiologist, pathologist and radiologist |                                              |                              |                        |
| Telemedicine/Virtual visit                              | 100% coverage after $35 PCP co-pay, subject to deductible | 70% coverage; subject to deductible | Not covered |

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**Benefits Comparison: HRA Plans**

January 1, 2019 - December 31, 2019

<table>
<thead>
<tr>
<th>Physicians' Services</th>
<th>Anthem Gold HRA Option</th>
<th>Anthem Silver HRA Option</th>
<th>Anthem Bronze HRA Option</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>In-Network</td>
<td>Out-of-Network</td>
<td>In-Network</td>
</tr>
<tr>
<td>Physician Services for Emergency Care</td>
<td>85% coverage; subject to deductible</td>
<td>80% coverage; subject to deductible</td>
<td>75% coverage; subject to deductible</td>
</tr>
<tr>
<td>Allergy Shots and Serum</td>
<td>85% coverage; subject to deductible</td>
<td>60% coverage; subject to deductible</td>
<td>80% coverage; subject to deductible</td>
</tr>
<tr>
<td>Outpatient Surgery/Services • When billed as an office visit</td>
<td>85% coverage; subject to deductible</td>
<td>60% coverage; subject to deductible</td>
<td>80% coverage; subject to deductible</td>
</tr>
<tr>
<td>Outpatient Surgery/Services • When billed as an outpatient surgery at a facility, including charges by surgeon, anesthesiologist, pathologist and radiologist</td>
<td>85% coverage; subject to deductible</td>
<td>60% coverage; subject to deductible</td>
<td>80% coverage; subject to deductible</td>
</tr>
<tr>
<td>Hospital Services</td>
<td>The Plan Pays</td>
<td>The Plan Pays</td>
<td>The Plan Pays</td>
</tr>
<tr>
<td>Inpatient Services • Inpatient care, delivery and inpatient short-term acute rehabilitation services</td>
<td>85% coverage; subject to deductible</td>
<td>60% coverage; subject to deductible</td>
<td>80% coverage; subject to deductible</td>
</tr>
<tr>
<td>Inpatient Services • Well newborn care</td>
<td>85% coverage; subject to deductible</td>
<td>60% coverage; subject to deductible</td>
<td>80% coverage; subject to deductible</td>
</tr>
<tr>
<td>Outpatient Surgery/Services • At a hospital or other facility</td>
<td>85% coverage; subject to deductible</td>
<td>60% coverage; subject to deductible</td>
<td>80% coverage; subject to deductible</td>
</tr>
<tr>
<td>Hospital Emergency Room Care • Treatment of an emergency medical condition or injury</td>
<td>85% coverage; subject to deductible</td>
<td>60% coverage; subject to deductible</td>
<td>80% coverage; subject to deductible</td>
</tr>
<tr>
<td>Outpatient Testing, Lab, etc.</td>
<td>The Plan Pays</td>
<td>The Plan Pays</td>
<td>The Plan Pays</td>
</tr>
<tr>
<td>Non-Routine Laboratory; X-Rays; Diagnostic Tests; Injections • Including medications covered under medical benefits–for the treatment of an illness or injury</td>
<td>85% coverage; subject to deductible</td>
<td>60% coverage; subject to deductible</td>
<td>80% coverage; subject to deductible</td>
</tr>
<tr>
<td>Complex Radiology Testing MRIs, CTs, PET and Nuclear Medicine</td>
<td>85% coverage; subject to deductible</td>
<td>60% coverage; subject to deductible</td>
<td>80% coverage; subject to deductible</td>
</tr>
</tbody>
</table>
## Benefits Comparison: HMO and HDHP Plans

### January 1, 2019 - December 31, 2019

<table>
<thead>
<tr>
<th>Physicians' Services</th>
<th>In-Network Only</th>
<th>Out-of-Network</th>
<th>In-Network Only</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physician Services for Emergency Care</td>
<td>100% coverage</td>
<td>70% coverage; subject to in-network deductible</td>
<td>100% coverage</td>
</tr>
<tr>
<td>Allergy Shots and Serum • Co-pay only applies when billed with an office visit</td>
<td>100% after $35 PCP co-pay $45 SPC co-pay</td>
<td>70% coverage; subject to deductible</td>
<td>100% after $35 PCP co-pay $45 SPC co-pay</td>
</tr>
<tr>
<td>Outpatient Surgery/Services • When billed as an office visit</td>
<td>100% after $35 PCP co-pay $45 SPC co-pay</td>
<td>70% coverage; subject to deductible</td>
<td>100% coverage after $100 co-pay</td>
</tr>
<tr>
<td>Outpatient Surgery/Services • When billed as an outpatient surgery at a facility; including charges by surgeon, anesthesiologist, pathologist and radiologist</td>
<td>80% coverage; subject to deductible</td>
<td>70% coverage; subject to deductible</td>
<td>50% coverage; subject to deductible</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Hospital Services</th>
<th>The Plan Pays</th>
<th>The Plan Pays</th>
<th>The Plan Pays</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient Services • Inpatient care, delivery and inpatient short-term acute rehabilitation services</td>
<td>80% coverage; subject to deductible</td>
<td>70% coverage; subject to deductible</td>
<td>50% coverage; subject to deductible</td>
</tr>
<tr>
<td>Inpatient Services • Well newborn care</td>
<td>100% coverage; not subject to deductible</td>
<td>70% coverage; subject to deductible</td>
<td>50% coverage; subject to deductible</td>
</tr>
<tr>
<td>Outpatient Surgery/Services • At a hospital or other facility</td>
<td>80% coverage; subject to deductible</td>
<td>70% coverage; subject to deductible</td>
<td>50% coverage; subject to deductible</td>
</tr>
<tr>
<td>Hospital Emergency Room Care • Treatment of an emergency medical condition or injury</td>
<td>100% coverage after $150 co-pay, if admitted co-pay waived</td>
<td>70% coverage; subject to in-network deductible</td>
<td>100% coverage after $150 co-pay, if admitted co-pay waived</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Outpatient Testing, Lab, etc.</th>
<th>The Plan Pays</th>
<th>The Plan Pays</th>
<th>The Plan Pays</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-Routine Laboratory; X-Rays; Diagnostic Tests; Injections • Including medications covered under medical benefits--for the treatment of an illness or injury</td>
<td>80% coverage; subject to deductible</td>
<td>70% coverage; subject to deductible</td>
<td>50% coverage; subject to deductible</td>
</tr>
<tr>
<td>Complex Radiology Testing MRIs, CTs, PET and Nuclear Medicine</td>
<td>80% coverage; subject to deductible</td>
<td>70% coverage; subject to deductible</td>
<td>50% coverage; subject to deductible</td>
</tr>
</tbody>
</table>
## Benefits Comparison: HRA Plans

### Anthem Gold HRA Option

<table>
<thead>
<tr>
<th>Behavioral Health/Other Coverage</th>
<th>In-Network</th>
<th>Out-of-Network</th>
<th>In-Network</th>
<th>Out-of-Network</th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental Health and Substance Use Disorder (MH/SUD)</td>
<td>85% coverage; subject to deductible</td>
<td>60% coverage; subject to deductible</td>
<td>85% coverage; subject to deductible</td>
<td>60% coverage; subject to deductible</td>
<td>85% coverage; subject to deductible</td>
<td>60% coverage; subject to deductible</td>
</tr>
<tr>
<td>Inpatient Facility and Residential Treatment Centers. <strong>NOTE:</strong> Prior approval required.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>MH/SUD: Group Outpatient Visits, Intensive Outpatient, Partial Day Hospitalization, and Methadone Clinics</td>
<td>85% coverage; subject to deductible</td>
<td>60% coverage; subject to deductible</td>
<td>85% coverage; subject to deductible</td>
<td>60% coverage; subject to deductible</td>
<td>85% coverage; subject to deductible</td>
<td>60% coverage; subject to deductible</td>
</tr>
<tr>
<td>MH/SUD: Outpatient Visits--Professional and Methadone Clinics</td>
<td>85% coverage; subject to deductible</td>
<td>60% coverage; subject to deductible</td>
<td>85% coverage; subject to deductible</td>
<td>60% coverage; subject to deductible</td>
<td>85% coverage; subject to deductible</td>
<td>60% coverage; subject to deductible</td>
</tr>
</tbody>
</table>

### Anthem Silver HRA Option

<table>
<thead>
<tr>
<th>Behavioral Health/Other Coverage</th>
<th>In-Network</th>
<th>Out-of-Network</th>
<th>In-Network</th>
<th>Out-of-Network</th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental Health and Substance Use Disorder (MH/SUD)</td>
<td>80% coverage; subject to deductible</td>
<td>60% coverage; subject to deductible</td>
<td>80% coverage; subject to deductible</td>
<td>60% coverage; subject to deductible</td>
<td>80% coverage; subject to deductible</td>
<td>60% coverage; subject to deductible</td>
</tr>
<tr>
<td>Inpatient Facility and Residential Treatment Centers. <strong>NOTE:</strong> Prior approval required.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>MH/SUD: Group Outpatient Visits, Intensive Outpatient, Partial Day Hospitalization, and Methadone Clinics</td>
<td>80% coverage; subject to deductible</td>
<td>60% coverage; subject to deductible</td>
<td>80% coverage; subject to deductible</td>
<td>60% coverage; subject to deductible</td>
<td>80% coverage; subject to deductible</td>
<td>60% coverage; subject to deductible</td>
</tr>
<tr>
<td>MH/SUD: Outpatient Visits--Professional and Methadone Clinics</td>
<td>80% coverage; subject to deductible</td>
<td>60% coverage; subject to deductible</td>
<td>80% coverage; subject to deductible</td>
<td>60% coverage; subject to deductible</td>
<td>80% coverage; subject to deductible</td>
<td>60% coverage; subject to deductible</td>
</tr>
</tbody>
</table>

### Anthem Bronze HRA Option

<table>
<thead>
<tr>
<th>Behavioral Health/Other Coverage</th>
<th>In-Network</th>
<th>Out-of-Network</th>
<th>In-Network</th>
<th>Out-of-Network</th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental Health and Substance Use Disorder (MH/SUD)</td>
<td>75% coverage; subject to deductible</td>
<td>60% coverage; subject to deductible</td>
<td>75% coverage; subject to deductible</td>
<td>60% coverage; subject to deductible</td>
<td>75% coverage; subject to deductible</td>
<td>60% coverage; subject to deductible</td>
</tr>
<tr>
<td>Inpatient Facility and Residential Treatment Centers. <strong>NOTE:</strong> Prior approval required.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>MH/SUD: Group Outpatient Visits, Intensive Outpatient, Partial Day Hospitalization, and Methadone Clinics</td>
<td>75% coverage; subject to deductible</td>
<td>60% coverage; subject to deductible</td>
<td>75% coverage; subject to deductible</td>
<td>60% coverage; subject to deductible</td>
<td>75% coverage; subject to deductible</td>
<td>60% coverage; subject to deductible</td>
</tr>
<tr>
<td>MH/SUD: Outpatient Visits--Professional and Methadone Clinics</td>
<td>75% coverage; subject to deductible</td>
<td>60% coverage; subject to deductible</td>
<td>75% coverage; subject to deductible</td>
<td>60% coverage; subject to deductible</td>
<td>75% coverage; subject to deductible</td>
<td>60% coverage; subject to deductible</td>
</tr>
</tbody>
</table>
## Benefits Comparison: HMO and HDHP Plans

**January 1, 2019 - December 31, 2019**

<table>
<thead>
<tr>
<th></th>
<th><strong>Anthem/UnitedHealthcare Statewide HMO Option</strong></th>
<th><strong>UnitedHealthcare HDHP Option</strong></th>
<th><strong>KP Regional HMO Option</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Behavioral Health</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mental Health and Substance Use Disorder (MH/SUD) Inpatient Facility and Residential Treatment Centers.*</td>
<td>80% coverage; subject to deductible</td>
<td>70% coverage; subject to deductible</td>
<td>100% after $250 co-pay *Contact KP directly for benefit coverage.</td>
</tr>
<tr>
<td>NOTE: Prior approval required.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>MH/SUD: Group Outpatient Visits, Intensive Outpatient, Partial Day Hospitalization, and Methadone Clinics*</td>
<td>100% after $35 PCP per visit. 100% after $45 SPC per visit. $10 co-pay for group therapy</td>
<td>70% coverage; subject to deductible</td>
<td>100% after $35 SPC per visit. $17 co-pay for group therapy *Contact KP directly for benefit coverage.</td>
</tr>
<tr>
<td>MH/SUD: Outpatient Visits--Professional and Methadone Clinics*</td>
<td>100% after $35 PCP co-pay $45 SPC co-pay</td>
<td>70% coverage; subject to deductible</td>
<td>100% after $35 SPC co-pay $45 SPC co-pay *Contact KP directly for benefit coverage.</td>
</tr>
<tr>
<td><strong>Other Coverage</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>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.</td>
<td>100% after $25 co-pay</td>
<td>70% coverage; subject to deductible</td>
<td>100% after $25 co-pay</td>
</tr>
<tr>
<td>Chiropractic Care Coverage up to a maximum of 20 visits per Plan Year</td>
<td>100% after $45 co-pay</td>
<td>70% coverage; subject to deductible</td>
<td>100% after $45 co-pay</td>
</tr>
<tr>
<td>Vision Routine Eye Exam Note: Limited to one eye exam every 24 months</td>
<td>100% coverage; not subject to deductible, in-network only 100% coverage; not subject to deductible Out-of-network Eye exam not covered</td>
<td>100% coverage; not subject to deductible</td>
<td>100% coverage; not subject to deductible in-network only</td>
</tr>
<tr>
<td>Hearing Services Routine Hearing Exam when properly coded as preventive</td>
<td>100% coverage</td>
<td>100% coverage; not subject to deductible</td>
<td>Not covered</td>
</tr>
<tr>
<td>Hearing Services Non-routine hearing not performed in an office setting</td>
<td>80% coverage; subject to deductible</td>
<td>70% coverage; subject to deductible</td>
<td>100% coverage; not subject to deductible</td>
</tr>
<tr>
<td><strong>Hearing Aid -- Adults Fittings</strong></td>
<td>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</td>
<td>70% coverage for exam and fittings; subject to deductible $1,500 hearing aid allowance every five years; subject to deductible</td>
<td>100% coverage for exam and fittings $1,500 hearing aid allowance every five years</td>
</tr>
<tr>
<td><strong>Hearing Aid -- Children (Up to age 19) Fittings</strong></td>
<td>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 the deductible</td>
<td>70% coverage for exam and fittings; subject to deductible $3,000 hearing aid allowance per hearing impaired ear every four years; subject to the deductible</td>
<td>100% coverage for exam and fittings $3,000 hearing aid allowance per hearing impaired ear every four years; not subject to deductible</td>
</tr>
</tbody>
</table>
## Benefits Comparison: HRA Plans

**January 1, 2019 - December 31, 2019**

<table>
<thead>
<tr>
<th>Other Coverage</th>
<th>Anthem Gold HRA Option</th>
<th>Anthem Silver HRA Option</th>
<th>Anthem Bronze HRA Option</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Applied Behavior Analysis</strong></td>
<td><strong>The Plan Pays</strong></td>
<td><strong>The Plan Pays</strong></td>
<td><strong>The Plan Pays</strong></td>
</tr>
<tr>
<td><strong>NOTE:</strong> Requires prior approval, only covered for treatment for autism spectrum disorders</td>
<td>85% coverage not subject to deductible</td>
<td>80% coverage not subject to deductible</td>
<td>75% coverage not subject to deductible</td>
</tr>
<tr>
<td></td>
<td>$35,000 benefit maximum per Plan Year</td>
<td>$35,000 benefit maximum per Plan Year</td>
<td>$35,000 benefit maximum per Plan Year</td>
</tr>
<tr>
<td><strong>Urgent Care Services</strong></td>
<td>85% coverage; subject to deductible</td>
<td>60% coverage; subject to deductible</td>
<td>80% coverage; subject to deductible</td>
</tr>
<tr>
<td></td>
<td>60% coverage; subject to deductible</td>
<td>80% coverage; subject to deductible</td>
<td>60% coverage; subject to deductible</td>
</tr>
<tr>
<td></td>
<td>80% coverage; subject to deductible</td>
<td>60% coverage; subject to deductible</td>
<td>75% coverage; subject to deductible</td>
</tr>
<tr>
<td></td>
<td>60% coverage; subject to deductible</td>
<td>60% coverage; subject to deductible</td>
<td>60% coverage; subject to deductible</td>
</tr>
<tr>
<td><strong>Home Health Care Services</strong></td>
<td>85% coverage; subject to deductible</td>
<td>60% coverage; subject to deductible</td>
<td>80% coverage; subject to deductible</td>
</tr>
<tr>
<td><strong>NOTE:</strong> Prior approval required</td>
<td>60% coverage; subject to deductible</td>
<td>80% coverage; subject to deductible</td>
<td>60% coverage; subject to deductible</td>
</tr>
<tr>
<td></td>
<td>Not Covered</td>
<td>80% coverage; up to 120 days per Plan Year; subject to deductible</td>
<td>Not Covered</td>
</tr>
<tr>
<td><strong>Skilled Nursing Facility Services</strong></td>
<td>85% coverage; up to 120 days per Plan Year; subject to deductible</td>
<td>Not Covered</td>
<td>75% coverage; up to 120 days per Plan Year; subject to deductible</td>
</tr>
<tr>
<td><strong>NOTE:</strong> Prior approval required</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Hospice Care</strong></td>
<td>85% coverage; subject to deductible</td>
<td>60% coverage; subject to deductible</td>
<td>80% coverage; subject to deductible</td>
</tr>
<tr>
<td><strong>NOTE:</strong> Prior approval required</td>
<td>60% coverage; subject to deductible</td>
<td>80% coverage; subject to deductible</td>
<td>60% coverage; subject to deductible</td>
</tr>
<tr>
<td></td>
<td>60% coverage; subject to deductible</td>
<td>60% coverage; subject to deductible</td>
<td>75% coverage; subject to deductible</td>
</tr>
<tr>
<td><strong>Durable Medical Equipment (DME) - Rental or purchase</strong></td>
<td>85% coverage; subject to deductible</td>
<td>60% coverage; subject to deductible</td>
<td>80% coverage; subject to deductible</td>
</tr>
<tr>
<td><strong>NOTE:</strong> Prior approval required for certain DME</td>
<td>60% coverage; subject to deductible</td>
<td>80% coverage; subject to deductible</td>
<td>60% coverage; subject to deductible</td>
</tr>
<tr>
<td></td>
<td>60% coverage; subject to deductible</td>
<td>60% coverage; subject to deductible</td>
<td>75% coverage; subject to deductible</td>
</tr>
<tr>
<td></td>
<td>60% coverage; subject to deductible</td>
<td>60% coverage; subject to deductible</td>
<td>60% coverage; subject to deductible</td>
</tr>
<tr>
<td><strong>Transplant Services</strong></td>
<td>Contact the Medical Claim Administrator for coverage details</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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, 2019 - December 31, 2019**

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

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, 2019 - December 31, 2019**

<table>
<thead>
<tr>
<th>Tier 1 Coverage</th>
<th>You Pay (In-Network)</th>
<th>You Pay (Out-of-Network*)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Co-insurance</td>
<td>15% ($20 min/$50 max); not subject to deductible</td>
<td>15% ($20 min/$50 max); not subject to deductible</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Tier 2 Coverage</th>
<th>You Pay (In-Network)</th>
<th>You Pay (Out-of-Network*)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Co-insurance Preferred Brand</td>
<td>25% ($50 min/$80 max); not subject to deductible</td>
<td>25% ($50 min/$80 max); not subject to deductible</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Tier 3 Coverage</th>
<th>You Pay (In-Network)</th>
<th>You Pay (Out-of-Network*)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Co-insurance Non-Preferred Brand</td>
<td>25% ($80 min/$125 max); not subject to deductible</td>
<td>25% ($80 min/$125 max); not subject to deductible</td>
</tr>
</tbody>
</table>

| 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/$312.50 max) | Tier 1–15% ($50 min/$125 max) Tier 2–25% ($125 min/$200 max) Tier 3–25% ($200 min/$312.50 max) | Tier 1–15% ($50 min/$125 max) Tier 2–25% ($125 min/$200 max) Tier 3–25% ($200 min/$312.50 max) |

*NOTE: For HRA Out-of-Network, please refer to the Health Reimbursement Arrangement (HRA) plan option Summary Plan Description (SPD).*

**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 Anthem HRA Plan Options.
Benefits Comparison:  
HMO and HDHP Pharmacy

January 1, 2019 - December 31, 2019

<table>
<thead>
<tr>
<th>Other Coverage</th>
<th>You Pay</th>
<th>The Plan Pays</th>
<th>You Pay</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Tier 1</strong> Co-insurance</td>
<td>$20 co-pay</td>
<td>70% coverage; after deductible is met</td>
<td>$20 co-pay</td>
</tr>
<tr>
<td><strong>NOTE</strong>: per 31-day maximum supply. KP per 30-day max.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Tier 2</strong> Co-insurance Preferred Brand</td>
<td>$50 co-pay</td>
<td>70% coverage; after deductible is met</td>
<td>$50 co-pay</td>
</tr>
<tr>
<td><strong>NOTE</strong>: per 31-day maximum supply. KP per 30-day max.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Tier 3</strong> Co-insurance Non-Preferred Brand</td>
<td>$90 co-pay</td>
<td>70% coverage; after deductible is met</td>
<td>$80 co-pay</td>
</tr>
<tr>
<td><strong>NOTE</strong>: per 31-day maximum supply. KP per 30-day max.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Participating 90-day Voluntary Mail Order OR Retail 90-day Network</td>
<td>Tier 1–$50 Tier 2–$125 Tier 3–$225 co-pays</td>
<td>70% coverage; after deductible is met</td>
<td>Tier 1–$50 Tier 2–$125 Tier 3–$200 co-pays</td>
</tr>
</tbody>
</table>

**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, please refer to the High Deductible Health Plan (HDHP) plan option Summary Plan Description (SPD).

**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 Anthem 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).

Who is eligible for enrollment in the TRICARE Supplement Plan?

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

- Retired military receiving retired, retainer or equivalent pay.
- Retired Reservists between the ages of 60 and 65.
- Retired Reservists under age 60 and enrolled in TRICARE Retired Reserve (TRR).
- Qualified National Guard and Reserve Members enrolled in TRICARE Reserve Select (TRS)
- Spouses/surviving spouses of any of the above

Points to consider if you elect TRICARE Supplement Plan coverage

- Effective January 1, 2019, 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

For complete information about eligibility and benefits, contact 866-637-9911 or visit www.selmantricareresource.com/ga_shbp. You may also find information at www.shbp.georgia.gov.
The State Health Benefit Plan (SHBP) is excited to continue working with our Wellness partner, Sharecare. If you elect Anthem 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.

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 Test 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.
### 2019 Well-Being Incentives for
Anthem and UnitedHealthcare Commercial Plan Options*

Members and their Covered Spouse can each earn 480 well-being Incentive Points and choose to redeem** for either: 1) a $150 Visa Gift Card (when redeeming all 480 well-being incentive points earned in 2019) OR 2) 480 well-being incentive credits (to apply toward eligible medical or pharmacy expenses)***

For details or questions, go to [www.BeWellSHBP.com](http://www.BeWellSHBP.com) or call 888-616-6411

<table>
<thead>
<tr>
<th>If You Complete…</th>
<th>You Will Earn…</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>The RealAge Test</strong>&lt;br&gt;Take a confidential, online questionnaire that will take about 10 minutes to complete. It is recommended that you complete the RealAge test early in 2019 to allow for completion of action items below.</td>
<td>120 well-being incentive points****</td>
</tr>
<tr>
<td><strong>A Biometric Screening</strong>&lt;br&gt;You have two options to complete your Biometric Screening: through your physician or at an SHBP-sponsored screening event.</td>
<td>120 well-being incentive points****</td>
</tr>
<tr>
<td><strong>The Coaching Pathway, Online pathway, or a Combination of Both</strong>&lt;br&gt;Up to 240 well-being incentive points in the following increments****.</td>
<td></td>
</tr>
<tr>
<td><strong>Telephonic Coaching Pathway</strong>&lt;br&gt;Actively engage in telephonic coaching with a Sharecare wellness coach.</td>
<td></td>
</tr>
<tr>
<td><strong>Online Pathway or Challenges</strong>&lt;br&gt;Complete either:&lt;br&gt;• Green Days within the challenge period, which include daily trackers such as steps, sleep, stress, blood pressure, weight, and smoking; or&lt;br&gt;• Complete the monthly 5K Steps Challenge per day&lt;br&gt;Log 8 Green Day trackers or 5K Steps per day monthly within the Sharecare app or on the online platform.</td>
<td><strong>Telephonic Coaching Pathway</strong>&lt;br&gt;• Earn 60 well-being incentive points for each completed coaching call per calendar month, up to 4 times.&lt;br&gt;• Maximum of one call in a calendar month qualifies you for the 60 well-being incentive points.&lt;br&gt;• Maximum of 240 well-being incentive points. <strong>Online Pathway or Challenges</strong>&lt;br&gt;• Earn 120 well-being incentive points up to 2 times, for a maximum of 240 well-being incentive points by completing two of the following challenges:&lt;br&gt;• Complete 60 of 90 Green Days Challenge (3 separate periods will be offered from January 1, 2019 – November 30, 2019)&lt;br&gt;• Complete 5K Steps Challenge per day (Monthly steps challenges will be offered from January 1, 2019 – November 30, 2019)</td>
</tr>
</tbody>
</table>

*All actions must be completed and appropriate documentation (including the Biometric Screening through your physician by completing the Physician Screening Form or at an SHBP-sponsored screening event) submitted and received by Sharecare between January 1, 2019 and November 30, 2019. It is your responsibility to ensure your information is complete and all documentation is received by Sharecare by November 30, 2019.**

Well-being Incentive Points are saved in the Sharecare Redemption Center until you choose to redeem them, meaning well-being incentive points will not be sent automatically to Anthem or UnitedHealthcare. Therefore, Members must make their selection on how they choose to redeem their points through the Redemption Center, by visiting [www.BeWellSHBP.com](http://www.BeWellSHBP.com).

***If you elect to redeem all 480 well-being incentive points earned in 2019 for the $150 Visa Gift Card, it can be used anywhere Visa is accepted and will be physically mailed within 2 weeks of redemption. If you elect to redeem your points for well-being incentive credits to apply toward eligible medical and pharmacy expenses, you may do so in increments of 120 (up to a maximum of 480). Credits will be available within 30 days of redemption and will be deposited into your HRA, MIA, or HIA account. You will not be able to select the Visa Gift Card option if you begin redeeming well-being incentive points.

****Note: Well-being incentive points 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 well-being incentive points upon RealAge test completion.

To learn more about how well-being incentives work with your Plan Option, please see the chart on the next page: “How Your Well-being Incentive Credits Work with Your Plan Option”
How Your Well-being Incentive Credits Work with Your Plan Option

For well-being incentive points earned through Sharecare, after you choose to redeem your points with the Sharecare Redemption Center for well-being incentive credits to apply toward eligible medical and pharmacy expenses (which you may do so in increments of 120 up to a maximum of 480), credits will be available within 30 days of redemption and will be deposited into your MIA, HRA, or HIA account. See 2019 Well-Being Incentives for Anthem and UnitedHealthcare Commercial Plan Options Chart for details.

<table>
<thead>
<tr>
<th>Plan Option</th>
<th>Account Type</th>
<th>When You Must Redeem Your Points for Credits</th>
<th>How Your Credits Work</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Anthem HMO</strong></td>
<td>MyIncentive Account (MIA)</td>
<td>All well-being incentive points earned in 2019 must be redeemed through Sharecare’s Redemption Center (well-being incentive points will not be sent automatically to your Medical Claims Administrator).</td>
<td>When you use your benefits, you pay the member responsibility, including provider/pharmacy co-pay, co-insurance or deductible 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 member responsibility that you’ve paid, Anthem will mail you a reimbursement check (up to the amount of MIA credits available) along with a MIA summary.</td>
</tr>
<tr>
<td><strong>Anthem HRA</strong></td>
<td>Health Reimbursement Account (HRA)</td>
<td>Members enrolled in a HRA plan option receive account based credits funded by SHBP, which are available immediately and do not require redemption in the Sharecare Redemption Center. All well-being incentive points earned in 2019 must be redeemed through Sharecare’s Redemption Center (well-being incentive points will not be sent automatically to your Medical Claims Administrator).</td>
<td>When you use your benefits, any funds that are owed to providers/pharmacies will be automatically paid by Anthem out of your HRA first. You will not pay anything until all of your available HRA credits have been used.</td>
</tr>
<tr>
<td><strong>UnitedHealthcare HMO</strong></td>
<td>Health Incentive Account (HIA)</td>
<td>Members enrolled in the UnitedHealthcare HMO receive a credit match funded by UnitedHealthcare. All well-being incentive points earned in 2019 must be redeemed through Sharecare’s Redemption Center (well-being incentive points will not be sent automatically to your Medical Claims Administrator).</td>
<td>When you use your benefits, you pay the provider/pharmacy co-pay, co-insurance or deductible 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).</td>
</tr>
<tr>
<td><strong>UnitedHealthcare HDHP</strong></td>
<td>Health Incentive Account (HIA)</td>
<td>Members enrolled in the UnitedHealthcare HDHP receive a credit match funded by UnitedHealthcare. All well-being incentive points earned in 2019 must be redeemed through Sharecare’s Redemption Center (well-being incentive points will not be sent automatically to your Medical Claims Administrator).</td>
<td>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).</td>
</tr>
</tbody>
</table>

*Portion of Your Deductible:
You: $1,350
You + Child(ren): $2,700
You + Spouse: $2,700
You + Family: $2,700
The above amounts reflect a portion of the total required Deductible.

**Note:** If you terminate your coverage with SHBP, any unused MIA, HRA, or HIA credits will be forfeited.
State Health Benefit Plan (SHBP) is excited to continue to partner with Kaiser Permanente (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, and online and onsite healthy living classes. To learn more about KP 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 2018 that have unused incentive credits earned in SHBP’s Be Well SHBP program administered by Sharecare. The balance will roll over in April 2019. With the KPRA, members will be able to use those unused credits for eligible medical and pharmacy expenses incurred after April 2019, while insured under the KP Regional HMO plan. If you have questions regarding your KPRA, contact KPRA customer service after April 2019 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.
2019 Wellness Incentives for 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](http://my.kp.org/shbp) and make sure you are up-to-date on all four of the activities listed below. Each member and their covered spouse who satisfies the KP Wellness Program requirements will receive a $500 Mastercard reward 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](http://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](http://my.kp.org/shbp) or call 866-300-9867.

**NOTE:** All actions must be completed between January 1, 2019 and November 30, 2019.

<table>
<thead>
<tr>
<th>What to Do</th>
<th>What You will Earn</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1.</strong> Take Your Total Health Assessment: Complete your KP on-line Total Health Assessment (THA). The questionnaire is confidential and only takes about 20 minutes.</td>
<td>How will YOU use your $500 Wellness Incentive reward? Complete all four activities and earn a Mastercard reward card worth $500.</td>
</tr>
<tr>
<td><strong>2.</strong> 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. <strong>NOTE:</strong> ONLY those screenings performed by KP are eligible for the reward.</td>
<td>• 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</td>
</tr>
<tr>
<td><strong>3.</strong> Get Yourself Screened: Complete all age and gender appropriate preventive screenings for breast, cervical or colorectal cancer.</td>
<td><strong>Both members and their covered spouses are eligible to earn the incentive for a total of $1000 per household.</strong></td>
</tr>
<tr>
<td><strong>4.</strong> Take an Online Course: Complete one online Healthy Lifestyle Program (HLP)</td>
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</tbody>
</table>

**Note:** If you terminate your coverage with SHBP, any unused KPRA credits will be forfeited.
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 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. To learn more, Members enrolled in Anthem and UnitedHealthcare should visit [www.BeWellSHBP.com](http://www.BeWellSHBP.com) and Members enrolled in KP should visit [www.my.kp.org/shbp](http://www.my.kp.org/shbp).

**Tobacco Cessation Medications**
Prescription and over-the-counter (OTC) tobacco cessation therapies, including nicotine replacement therapy (NRT), are available. For Members enrolled in Anthem and UnitedHealthcare, please go to [http://info.caremark.com/shbp](http://info.caremark.com/shbp) to learn more. For Members enrolled in KP, please go to [www.my.kp.org/shbp](http://www.my.kp.org/shbp) to learn more.

**Tobacco Surcharge**
Tobacco surcharges are included in all SHBP Plan 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](http://www.shbp.georgia.gov) to access the tobacco surcharge removal 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 2019 by completing the Tobacco Surcharge Removal Requirements in the Tobacco Users Cessation Policies for Anthem, UnitedHealthcare and KP at: [www.shbp.georgia.gov](http://www.shbp.georgia.gov).
If You Are Retiring

Planning to Retire Soon? Here’s 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 member 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. This also applies to any dependent(s) you would like to cover as a retiree, which means you will need to enroll your dependent(s) during Open Enrollment the year prior to your retirement while you are still an active member if you would like them to be covered when you retire.

• 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 members 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 members 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 you or your covered dependents are age 65 or older (or will be turning age 65 at your retirement), you have the option of: 1) enrolling in a SHBP Medicare Advantage with Prescription Drugs (MAPD) Plan Option if you submit your Medicare Part B enrollment information directly to SHBP, or 2) remaining in a Commercial (Non-Medicare Advantage) Plan Option, and you will pay 100% of the unsubsidized premium, which is substantially higher than the SHBP Medicare Advantage Plan Options. 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 Plan Options as a Retiree.
IT’S NEVER TOO EARLY OR TOO LATE TO WORK TOWARDS BEING THE HEALTHIEST YOU
Legal Notices

About the Following Notices

The following important legal notices are also posted on the State Health Benefit Plan (SHBP) website at www.shbp.georgia.gov under Plan Documents:

Penalties for Misrepresentation

If a SHBP participant misrepresents eligibility information when applying for coverage during change of coverage or when enrolling in benefits, the SHBP may take adverse action against the participant, including but not limited to terminating coverage (for the participant and his or her dependents) or imposing liability to the SHBP for fraud and indemnification (requiring payment for benefits to which the participant or his or her beneficiaries were not entitled). Penalties may include a lawsuit, which may result in payment of charges to the Plan or criminal prosecution in a court of law.

To avoid enforcement of the penalties, the participant must notify the SHBP immediately if a dependent is no longer eligible for coverage or if the participant has questions or reservations about the eligibility of a dependent. This policy may be enforced to the fullest extent of the law.

Federal Patient Protection and Affordable Care Act Notices

Choice of Primary Care Physician

The Plan generally allows the designation of a Primary Care Physician (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

If you decline enrollment for yourself or your Dependents (including your spouse) because of other health insurance or group health plan coverage, you may be enrolled by yourself and your Dependents if you or your Dependents lose eligibility for that other coverage (or if the employer stops contributing towards your or your Dependents’ other coverage). However, you must request enrollment within thirty-one (31) days after your or your Dependents’ other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new Dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your new Dependents. However, you must request enrollment within thirty-one (31) days after the marriage or adoption, or placement for adoption (or within 90 days for a newly eligible dependent child).

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 SHBP Member Services at 1-800-610-1863 or visit the SHBP Enrollment Portal: www.mySHBPga.adp.com.

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.

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).

About the Following Notices

The following important legal notices are also posted on the State Health Benefit Plan (SHBP) website at www.shbp.georgia.gov under Plan Documents:

Penalties for Misrepresentation

If a SHBP participant misrepresents eligibility information when applying for coverage during change of coverage or when enrolling in benefits, the SHBP may take adverse action against the participants, including but not limited to terminating coverage (for the participant and his or her dependents) or imposing liability to the SHBP for fraud and indemnification (requiring payment for benefits to which the participant or his or her beneficiaries were not entitled). Penalties may include a lawsuit, which may result in payment of charges to the Plan or criminal prosecution in a court of law.

To avoid enforcement of the penalties, the participant must notify the SHBP immediately if a dependent is no longer eligible for coverage or if the participant has questions or reservations about the eligibility of a dependent. This policy may be enforced to the fullest extent of the law.

Federal Patient Protection and Affordable Care Act Notices

Choice of Primary Care Physician

The Plan generally allows the designation of a Primary Care Physician (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

If you decline enrollment for yourself or your Dependents (including your spouse) because of other health insurance or group health plan coverage, you may be enrolled by yourself and your Dependents if you or your Dependents lose eligibility for that other coverage (or if the employer stops contributing towards your or your Dependents’ other coverage). However, you must request enrollment within thirty-one (31) days after your or your Dependents’ other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new Dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your new Dependents. However, you must request enrollment within thirty-one (31) days after the marriage or adoption, or placement for adoption (or within 90 days for a newly eligible dependent child).

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 SHBP Member Services at 1-800-610-1863 or visit the SHBP Enrollment Portal: www.mySHBPga.adp.com.

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.

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).
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.

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.

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.

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
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/plan-documents-policies-forms. To request a paper copy, please contact SHBP Member Services at 800-610-1863.

Georgia Law Section 33-30-13 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 Open Enrollment (OE) Available

October 15 at 12:00 a.m. through November 2 at 11:59 p.m. ET
For Plan Coverage effective January 1, 2019 – December 31, 2019

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 and 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 Plan Options are established by the DCH Board and may be changed at any time by Board Resolutions subject to advance notice.