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

My 2016 SHBP Decision Guide

Retired Employee

Retiree Option Change Period October 19 - November 6, 2015

www.mySHBPga.adp.com

Resources/Contact Information
State Health Benefit Plan (SHBP)

Medical Claims Administrator	Member Services	Website
Blue Cross and Blue Shield of Georgia (BCBSGa)		
Member Services: Monday thru Friday, 8:00 a.m. to 8:00 p.m. ET	855-641-4862 (TTY 711)	www.bcbsga.com/shbp
Fraud Hotline	800-831-8998	
UnitedHealthcare		
Member Services: Monday thru Friday, 8:00 a.m. to 8:00 p.m. ET (call 24 hours a day/7 days per week for Nurseline support)	888-364-6352 (TTY 711)	www.welcometouhc.com/shbp
Fraud Hotline	866-242-7727	
Kaiser Permanente (KP)		
Member Services: Monday thru Friday, 7:00 a.m. to 7:00 p.m. ET. (Call 24 hours a day/7 days per week for Appointment Scheduling- Prescriptions and Nurse Advice)	855-512-5997 (TTY 711)	my.kp.org/shbp
Wellness Program Customer Service	866-300-9867	my.kp.org/shbp
Fraud Hotline	855-512-5997	
Wellness Program Administrator	**Member Services**	**Website**
Healthways Member Services: Monday thru Friday, 8:00 a.m. to 8:00 p.m. ET	888-616-6411 (TTY 711)	www.BeWellSHBP.com
Corporate Compliance	866-225-0836 (TTY 711)	
Pharmacy Administrator	**Member Services**	**Website**
Express Scripts Member Services: 24 hours a day/7 days per week	877-841-5227 866-707-1862 Commercial 877-804-9222 Specialty	www.express-scripts.com/GeorgiaSHBP
Fraud Hotline	866-216-7096	
SHBP	**Member Services**	**Website**
SHBP Member Services Monday thru Friday, 8:00 a.m. to 6:00 p.m. ET during Open Enrollment *Regular Business Hours 8:30 a.m. to 5:00 p.m. ET*	800-610-1863	www.mySHBPga.adp.com
Additional Information	**Member Services**	**Website**
PeachCare for Kids®	877-427-3224	www.peachcare.org
TRICARE Supplement	866-637-9911	www.selmantricareresource.com/ga_shbp
Social Security Administration	800-772-1213	www.ssa.gov
Centers for Medicare & Medicaid Services (CMS)	**Help Line**	**Website**
24 hours a day/7 days per week	800-633-4227 TTY 877-486-2048	www.medicare.gov

The material in this Decision Guide is for informational purposes only and is not a contract. It is intended only to highlight principal benefits of the SHBP Plan Options. Every effort has been made to be as accurate as possible; however, should there be a difference between this information and the Plan Documents, the Plan Documents govern. It is the responsibility of each member, active or retired, to read all Plan materials provided to fully understand the provisions of the option chosen. Availability of SHBP Options may change based on federal or state law changes or as approved by the Board of Community Health. Premiums for SHBP options are established by the Board of Community Health and may be changed at any time by Board Resolution, subject to advance notice.

Plan Year 2016 Retiree Option Change Period (ROCP)

Welcome to the State Health Benefit Plan's (SHBP) Retiree Option Change Period (ROCP) for the 2016 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 your, and your covered dependents health care needs.

Table of Contents

Common Health Care Acronyms

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

GEORGIA DEPARTMENT
OF COMMUNITY HEALTH

Nathan Deal, Governor **Clyde L. Reese III, Esq., Commissioner**

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

September 2015

Dear Valued State Health Benefit Plan Member:

Welcome to the Retiree Option Change Period (ROCP) for Plan Year (PY) 2016. You will make your health care elections online at **www.mySHBP.adp.com** from October 19,12:00 a.m. through November 6, 2015, 11:59 p.m.

In an effort to provide stability and continuity in plan choices, SHBP will continue to offer the same plan designs and vendors for PY 2016. To that end, retired Medicare-eligible members can enroll in one of two UnitedHealthcare Medicare Advantage (MA) plan options for the 2016 Plan Year.

MA Plan Options

- MA Plan Options (Standard and Premium)
- Members may use any provider who accepts Medicare and the UHC plan
- MA Plan Options are the only subsidized options for retirees age 65 and older

Non-MA Plan Options

- Gold, Silver, Bronze Health Reimbursement Arrangement (HRA) Plan Options
- Two Statewide Health Maintenance Organization (HMO) Plan Options
- A statewide High Deductible Health Plan (HDHP)
- Regional, fully-insured, in-network only HMO Plan Option (see Decision Guide for eligibility)

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

Sincerely,

Clyde L. Reese III, Esq.
Commissioner

Welcome to the Annual Retiree Option Change Period (ROCP)

Welcome to the Georgia Department of Community Health (DCH), State Health Benefit Plan (SHBP) 2015 Annual Retiree Option Change Period (ROCP).

During October 19 through November 6, 2015, over 630,000 eligible employees, retirees, and their families will have the opportunity to enroll and/or continue access to quality health insurance benefits offered through SHBP.

On behalf of Governor Nathan Deal, Commissioner Clyde Reese, the Board of Community Health and the entire SHBP team, I encourage you to explore the plan changes and plan options that are available to you for 2016.

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

This Retiree Decision Guide outlines specific benefit changes that will become effective January 1, 2016 and continue in effect through December 31, 2016. In addition to this guide, you may visit www.dch.georgia.gov/shbp for other helpful tools, including premium costs, qualifying event definitions and more.

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

Sincerely,

Jeff Rickman
Division Chief SHBP

Medical Claims Administrators, Plan Options and Enhanced Benefits for 2016

Medical Claims Administrators

Blue Cross and Blue Shield of Georgia (BCBSGa), UnitedHealthcare and Kaiser Permanente (KP) will continue to offer State Health Benefit Plan (SHBP) members the below Plan Options for 2016.

Plan Option Offerings

Health Maintenance Organization (HMO)

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

High Deductible Health Plan (HDHP)

- UnitedHealthcare

Health Reimbursement Arrangement (HRA) without co-pays

- BCBSGa
  - Gold, Silver and Bronze Plan Options

Medicare Advantage (MA) Preferred Provider Organization (PPO) Standard and Premium

- UnitedHealthcare

Additional Options

TRICARE Supplement
Peachcare for Kids®

New Benefit Enhancements

Telemedicine/Virtual Visits

Effective January 1, 2016, telemedicine/virtual visits will be available to SHBP members. Telemedicine allows health care professionals to evaluate, diagnose and treat patients using telecommunication technology. Through telemedicine/virtual visits, you will be able to see and talk to a participating doctor from your mobile device, tablet or computer with a webcam while at home, work or on the go.

For more information regarding the telemedicine/virtual visit benefit, please see the Benefits Comparison Table and/or contact your medical claims administrator's member services number.

Well-Being Incentive Credit Rollover Between Plan Options and Vendors

Members who are enrolled in BCBSGa HRA, BCBSGa and UnitedHealthcare HMO and UnitedHealthcare HDHP Plan Options will get to keep any unused well-being incentive credits if they remain continuously enrolled in a SHBP Plan Option. The unused well-being incentive credits will rollover to the 2016 Plan Year in April.

Additionally, all unused well-being incentive credits will rollover if you change vendors (BCBSGa, KP or UnitedHealthcare) and/or Plan Options (HRA, HMO or HDHP). If you enroll in Kaiser Permanente (KP) during OE, your unused well-being incentive credits will rollover into a Kaiser Permanente Rollover Account (KPRA). However, you will be ineligible to participate in the Healthways well-being incentive program.You will be eligible to participate in KP wellness incentive program.

This means no matter which Plan Option you select (excluding TRICARE Supplement), you will get to keep all unused well-being incentive credits you have earned.

Note: Your unused well-being incentive credits will rollover in April 2016. This allows 2015 well-being incentive credits to be used to pay your out-of-pocket expenses for 2015 claims filed after December 31, 2015. For additional information, please see the Wellness section of this Decision Guide.

New Benefit Enhancements (cont.)

2016 WELLNESS INCENTIVE CREDITS AT-A-GLANCE					
Plan Option	**BCBSGa HMO My Incentive Account (MIA)**	**BCBSGa Health Reimbursement Account (HRA)**	**Kaiser Permanente (KP)**	**UnitedHealthcare HMO Health Incentive Account (HIA)**	**UnitedHealthcare HDHP Health Incentive Account (HIA)**
Who's Eligible	Up to	Up to		Up to	Up to
Member	480 credits	480 credits	$240*	480 credits	480 credits
Spouse	480 credits	480 credits	$240*	480 credits	480 credits
Bonus credits for member**				240 credits**	240 credits**
Potential Total credits/dollars	960 credits	960 credits	$480*	1,200 credits	1,200 credits

**Kaiser members and their spouses will each receive a $240 Visa gift card after satisfying KP's Wellness Program requirements.*

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

IMPORTANT NOTE: HRA members will also receive SHBP-funded credits at the being of the Plan Year. The amount funded will be based on your elected coverage tier. If you enroll in the 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. For additional information, please see the Wellness Section in this Decision Guide, contact your medical claims administrator and/or Healthways at 888-616-6411. KP members should contact the wellness program customer service at 866-300-9867.

Bariatric Pilot

The 2016 Plan Year will be the second year of the two-year Bariatric Pilot program established by the Georgia General Assembly. The pilot program provides benefit coverage for selected SHBP members for certain bariatric surgical procedures for the treatment and management of obesity and related conditions.

The pilot program will be limited to a newly selected group of 75 non-Medicare Advantage members for the 2016 benefit year. SHBP members must complete and submit their application by February 4, 2016. Qualified applicants will be randomly selected by the medical claims administrator for which you are enrolled. If you submitted an application for the 2015 Plan Year and you were not selected, and wish to apply for the 2016 Plan Year, you must submit a new application for 2016 by the deadline. For more information about the Bariatric Pilot program, visit www.dch.georgia.gov/shbp or contact your medical claims administrator's member services number.

Photo credit: Georgia Department of Economic Development

Plan Changes for 2016

High Deductible Health Plan (HDHP) Deductible and Out-of-Pocket Maximum

Effective January 1, 2016, the Affordable Care Act (ACA) will limit the deductible and out-of-pocket maximum amounts to members enrolled in a coverage tier other than You (single). The You (single) coverage tier deductible and out-of-pocket maximum will now apply to each individual family member regardless of whether you cover more than one dependent or have family coverage. This means, if you have employee+child, employee+spouse or family coverage, **the entire family deductible NO LONGER has to be met before** benefits are payable for an individual family member. Also, once the You (single) coverage tier out-of-pocket maximum has been satisfied for that individual family member, all covered medical and pharmacy expenses will be paid at 100% for the Plan Year for that family member. Please note, however, each individual family member cannot contribute more than their own individual deductible and out-of-pocket maximum to the overall family deductible and out of pocket maximum.

For additional information, please see the section on How the High Deductible Health Plan Works.

Wellness

Good news! Regardless of the Plan Option you select, all unused well-being incentive credits earned while participating in SHBP's wellness program (currently through Healthways), will now rollover to any Plan Option (Health Maintenance Organization {HMO}, Health Reimbursement Arrangement {HRA} or High Deductible Health Plan {HDHP}) and/or vendor (Blue Cross and Blue Shield of Georgia {BCBSGa}, Kaiser Permanente {KP} or UnitedHealthcare) you choose during the Retiree Option Change Period (ROCP).

Kaiser Permanente Wellness Incentives

KP members and covered spouses can now each earn a $240 Visa gift card for the completion of specific wellness activities. See the KP Wellness Section of this Decision Guide for full details.

Important Wellness Note: There is still time for Blue Cross and Blue Shield of Georgia (BCBSGa) and UnitedHealthcare members and their covered spouses to earn the 2015 well-being incentive credits. If you have not completed the required health actions or have not taken any actions, you have until December 15, 2015 to earn the 2015 well-being incentive credits. And remember, any unused well-being incentive credits earned in 2015 will rollover in April 2016 to whichever plan option you choose and will help offset out-of-pocket expenses during the 2016 Plan Year. If you have questions or need help getting started, visit www.BewellSHBP.com or contact Healthways at 888-616-6411.

Also, KP members and their spouses still have time to participate in KP's 2015 wellness plan incentive program. KP members and their spouses have until November 30, 2015 to complete one wellness activity and be entered into a raffle for the chance to win an iPad and Fit Bit package. Visit KP's website at 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.

Request for Taxpayer Identification Number(s) to Meet Mandatory Patient Protection and Affordable Care Act Reporting

The Patient Protection and Affordable Care Act (ACA) requires individuals have Minimum Essential Coverage (unless an exemption is obtained), and also requires certain entities to transmit an information return to the IRS and a statement to individuals. The transmittal form to the Internal Revenue Service (IRS) must include a Taxpayer Identification Number (TIN) for all individuals. All members must provide SHBP their TIN for themselves and their dependents. The most common type of TIN is a Social Security Number (SSN), but for individuals who are not eligible for an SSN, members may submit an Individual Taxpayer Identification Number (ITIN) or Adoption Taxpayer Identification Number (ATIN). Please note that if the IRS cannot confirm that members and/or their dependents have Minimum Essential Coverage, members and/or their dependents may receive correspondence directly from the IRS requesting verification of coverage and failure to verify may result in an IRS tax penalty. Members may update or confirm SHBP has a TIN on file by accessing their account at https://mySHBPga.adp.com/shbp/.

ACTION ALERT

If you experience a Qualifying Event (QE) during the Plan Year that results in coverage under a new identification number (ID) or a change in Plan Option and/or vendor, your well-being incentive credits will be forfeited. The deductible and out-of-pocket maximum will not be transferred. The Health Reimbursement Arrangement (HRA) initial funding if moving to a new ID number will be prorated based on the elected coverage tier and months remaining in the current Plan Year. Deductibles and out-of-pocket maximums are not prorated.

Photo credit: Georgia Department of Economic Development

Retiree Option Change Period (ROCP) and Your Responsibilities

Website for the ROCP available from October 19 at 12:00 a.m. through November 6, 2015 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 6, 2015 by 11:59 p.m. ET
- Read and make sure you understand the plan materials posted at www.dch.georgia.gov/shbp-plan-documents and take the required actions
- Check your health insurance deduction to verify the correct deduction amount is made
- Update any change in address by making the correction online at www.mySHBPga.adp.com during ROCP or call SHBP Member Services at 800-610-1863 for assistance
- Pay all required premiums by the due date if they are not automatically deducted from your retirement annuity
- 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)
- Continue to pay Medicare Part B premium if you are in a Medicare Advantage (MA) PPO Plan Option

During ROCP, you may:

- Change to any Plan Option for which you are eligible (if you and/or your covered spouse are age 65 or older and do not enroll in a MA PPO Plan Option, you will pay the higher, unsubsidized cost of the coverage)
- Enroll in a new plan option
- Drop covered dependents
- Discontinue SHBP coverage

IMPORTANT NOTE:

- If you discontinue your SHBP coverage for any reason, you will not be able to re-enroll unless you return to work in a position that offers SHBP benefits
- If you return to work after retiring, you will need to have health insurance premiums deducted from your paychecks as an active employee. Upon retiring again, you must notify SHBP's Member Services at 800-610-1863 within 31 days to request coverage as a retiree or you will no longer have coverage with SHBP
- When you retire, your deductions will be taken from your retirement annuity check. If your retirement annuity check does not cover the cost of your premium, you MUST set up a direct pay billing arrangement. For more information, call the SHBP Member Services at 800-610-1863
- The election made during the 2015 ROCP will be the coverage you have for the entire 2016 Plan Year unless you have a QE that allows a change in your coverage
- Enrolling or discontinuing coverage from individual coverage offered through the Health Insurance Marketplace is NOT a QE

Making Your Health Benefit Election for 2016

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

If you are unable to make your election online or need technical assistance, you may call the SHBP Member Services at 800-610-1863.

Retiree Option Change Period (ROCP) begins October 19, 2015, 12:00 a.m. ET and ends November 6, 2015, 11:59 p.m. ET.

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:

• If you are enrolled in a Medicare Advantage (MA) Preferred Provider Organization (PPO) Plan Option in 2015 – you will remain in your current MA Plan Option and tier with UnitedHealthcare for the 2016 Plan Year.

• If you are enrolled in a Non-MA option in 2015 – you will be you will remain in your current Plan Option and tier with your current medical claims administrator in 2016.

NOTE: If you paid a Tobacco Surcharge in 2015, it will continue to apply. If you did not pay a Tobacco Surcharge in 2015, you will not pay one if you default coverage. Remember, it is your obligation to notify the SHBP immediately if you no longer qualify for the Tobacco Surcharge to be waived.

• If you are enrolled in the TRICARE Supplement in 2015 you will be enrolled in the TRICARE Supplement for 2016.

How to Make Your 2016 Health Benefit Election

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

Step 1: Log on to the Enrollment Portal. (If you are a first time user, you must first register using the registration code **SHBP-GA** and set up a password before making your 2016 election. If you are a returning user but have not accessed the website since 09/15/15, then you must first reset your password before making your 2016 election.)

- The Home page displays a **ROCP** message indicating the event date for you on the top of the screen for elections to be in effect for the 2016 Plan Year.

NOTE: You will be able to elect a Dependent Health Benefit Option if you are in a Split Option. If you are not in a Split Option, you will not be able to make a Dependent Health Benefit election.

Step 2: Under the Open Enrollment window, **click** on **Continue** to proceed with your 2016 Plan Year enrollment.

Step 3: The Welcome page displays a Terms and Conditions message with the new Plan Year as the effective date.

- You should **click** on the **message** to review Terms and Conditions before accepting. You must **click Accept Terms and Conditions** to continue to the next step of enrollment.

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

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

NOTE: You can only add a dependent(s) if you have a Qualifying Event (QE)

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

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

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

Step 8: **Click** on **Go to Health Benefits** to choose your medical claims administrators and Plan Options.

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.

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

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

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

Step 11: **Click Finish**.

NOTE: If Finish is NOT clicked, your enrollment process has not been completed. After ROCP all members and dependents, if applicable, will be issued new Identification cards(ID) by their selected medical claims administrator.

Retiree Option Change Period (ROCP) Checklist

- ☑ Verify all desired dependents are listed on the Confirmation Page and have valid SSN
- ☑ 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 you have answered the Tobacco Surcharge question appropriately (applicable to Non-MA only)
- ☑ 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 ROCP will be your option for 2016, unless you experience a Qualifying Event (QE) that allows you to make a change.

Take Advantage of Decision Support Tools to Help You Select the Health Care Option that Best Meet Your Personal and Financial Needs! (Non-Medicare Advantage Only)

To help you with your enrollment choices, 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 and your covered dependents' personal needs and circumstances.

Within the Decision Support Tools, there are three interactive, easy-to-use modules to help you evaluate, identify and select the health care options best suited to your personal and financial needs. They are:

Tool #1: Medical Cost Calculator

To understand which Plan Option best meets your needs, it is important to consider both the premiums and the expenses you may incur during the Plan Year. With the Medical Cost Calculator, you use simple drop-down boxes to estimate how frequently you expect to use a variety of common services, including office visits, X-rays, prescriptions and more.

Tool #2: Preference Module

Health care utilization is highly individual. The Preference Module enables you to consider which features matter most to you and your family and rate the importance of each attribute you select. Plan Options are then presented to you in a customized, best-fit order for easy side-by-side comparisons.

Tool #3: Comparison Module

You may have very specific needs in mind when comparing Plan Options. The Comparison Module allows you to easily drill down to the precise information you need to ensure that you obtain the coverage you require at the most cost-effective rate.

Flexible Benefits Program

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

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

Photo credit: Georgia Department of Economic Development

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 the 2015 Retiree Option Change Period (ROCP) will be the coverage you have for the entire 2016 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 your Eligibility and Enrollment Provisions document available online at www.dch.georgia.gov/shbp. You may also contact the SHBP Member Services for assistance at 800-610-1863.

QEs include, but are not limited to:

- Birth, adoption of a child, or placement for adoption
- Death of a spouse or child, only if the dependent is currently enrolled
- Your spouse's or dependent's loss of eligibility for other group health coverage
- Marriage or divorce
- Medicare eligibility
- Gain or loss of PeachCare for Kids® or Medicaid eligibility

Eligible Dependents

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

- Spouse (includes same sex)
- Dependent Child
  - Natural child
  - Adopted child
  - Stepchild
  - Guardianship
  - Totally disabled child

How to Declare a Qualifying Event (QE)

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

- Remember you only have 31 days after a QE to add a dependent, e.g., adding a spouse
- You have 90 days to add a newly eligible dependent child and submit the Social Security Number (SSN)
- Members who do not have web access may call SHBP Member Services at 800-610-1863 and a representative will assist you with making the change

ACTION ALERT

If you adopt a child or become a legal guardian, you may have to change tiers and MUST add your child and submit the SSN within 90 days. For a complete description of eligibility, see your Eligibility and Enrollment Provisions document available online at www.dch.georgia.gov/shbp.

Photo credit: Georgia Department of Economic Development

2016 Medicare Advantage (MA) Preferred Provider Organization (PPO) Plan Options

The 2016 MA PPO Plan Options are listed below.

- UnitedHealthcare MA PPO Standard
- UnitedHealthcare MA PPO Premium

The MA PPO Plan Option is an approved plan by the Centers for Medicare & Medicaid Services (CMS); it is sometimes called a Part C Plan. This plan takes the place of your original Medicare Part A – Hospital, Medicare Part B – Medical and includes Medicare Part D, a prescription drug benefit. This plan is very similar to a traditional PPO plan. You may receive benefits from in-network and out-of-network providers as long as the provider accepts Medicare.

The MA PPO Plan Option also provides a contracted network on a statewide and national basis across the United States. You will have the choice of an MA PPO Standard or Premium plan under UnitedHealthcare. Additionally, you can see non-contracted providers as long as they accept Medicare.

- You do not have to select a Primary Care Physician (PCP) or obtain a referral to see a Specialist (SPC)
- Co-pays apply toward the out-of-pocket maximum (except for prescription drugs)
- Unlike traditional PPO plans, there is no difference in your co-pay/co-insurance levels if you see providers who are contracted (in-network) or providers who are not contracted (out- of-network). So, you are not penalized for going to a non-contracted provider
- There will be no coverage if you see a provider who does not accept Medicare
- Enrollment in the MA PPO plans is subject to CMS approval and is prospective (retroactive enrollment is not generally allowed)
- **CMS requires a physical street address** and Medicare number before approving MA PPO coverage
- Once approved, CMS will notify the State Health Benefit Plan (SHBP) of the effective date of your coverage
- You will receive a new insurance card that you will show (in place of your Medicare card) when receiving service

When someone you cover is not eligible to participate in the MA PPO option, it is called split eligibility. This means that the individual with Medicare enrolls in the MA PPO option and any family members who are not eligible for Medicare can enroll in one of the other Plan Options offered by SHBP, excluding TRICARE Supplement.

Photo credit: Georgia Department of Economic Development

IF 65 OR OLDER WITH MEDICARE

If 65 or older with Medicare	*Then...*
• Stop Paying Part B and/or • Enroll in a non-State Health Benefit Plan (SHBP) MA Plan, Medicare Supplemental Plan or Part D Prescription Plan	Your Medicare Advantage (MA) coverage under SHBP will be terminated and SHBP will move you to the Blue Cross Blue Shield Bronze Health Reimbursement Arrangement (HRA) option and you will pay 100% of the unsubsidized premium.
Without Medicare Part B	You may enroll in the Gold, Silver or Bronze HRA; one of the Health Maintenance Organizations (HMO); or the High Deductible Health Plan (HDHP) Plan Options and you will pay 100% of unsubsidized premium. -OR- Purchase Part B to enroll in an MA option; however, you will be responsible for paying the Late Enrollment Penalty. If you are enrolling late in Medicare after your Initial Enrollment Period for Medicare Parts A and/or B, the General Enrollment Period is January 1st through March 31st and the coverage will be effective July 1st of that year.

Prescription Drug Coverage Under the MA Preferred Provider Organization (PPO) Plan Options

UnitedHealthcare includes Medicare Part D drug coverage.

UnitedHealthcare Select Generic Program

The Select Generic Program is designed to help members reduce their out-of-pocket costs with a $0 co-pay on certain prescription medications. With this program, members have access to select generic drug benefits at no cost share at any network retail pharmacy or through mail-order pharmacy. A list of the select generic prescription medications for 2016 is available at www.uhcretiree.com/shbp.

Benefits Comparison: Medicare Advantage (MA) Preferred Provider Organization (PPO) Standard and Premium Plans

January 1, 2016 – December 31, 2016

	MA PPO – Standard UnitedHealthcare	MA PPO – Premium UnitedHealthcare
Covered Services	**You Pay**	**You Pay**
Deductibles	$0	$0
Out-of-Pocket Maximum Per Member[1]	$3,500 per member	$2,500 per member
Physicians' Services	**You Pay**	**You Pay**
Primary Care Physician or Specialist Office or Clinic Visits Treatment of illness or injury	PCP—$25 per office visit co-pay; SPC—$30 per office visit co-pay	PCP—$15 per office visit co-pay; SPC—$25 per office visit co-pay
Primary Care Physician or Specialist Office or Clinic Visits Annual Wellness Visit	$0 co-pay	$0 co-pay
Complex Radiology Services and Radiation Therapy Received in a Doctor's Office[2] (Doctor's office visit co-pay will apply)	$35 co-pay	$35 co-pay
Diagnostics Procedures and Testing Services Received in a Doctor's Office (Doctor's office visit co-pay will apply)	$0 co-pay	$0 co-pay
Annual Screenings Note: Pap smears are covered every 24 months unless high risk, then annually.	$0 co-pay; (mammograms, pap smears, prostate cancer screening, colorectal cancer screening)	$0 co-pay; (mammograms, pap smears, prostate cancer screening, colorectal cancer screening)
Hospital Services	**You Pay**	**You Pay**
Inpatient Hospital Services	20% co-insurance	20% co-insurance
Outpatient Hospital Services (includes observation, medical and surgical care)	$95 co-pay Observation Room $25 co-pay PCP $30 co-pay SPC	$50 co-pay Observation Room $15 co-pay PCP $25 co-pay SPC
Complex Radiology Service and Radiation Therapy Service[2] (When the service is performed at a hospital, outpatient facility or a free-standing imaging or diagnostic center)	20% co-insurance	20% co-insurance
Diagnostic Procedures and Testing Services (When the service is performed at a hospital, outpatient facility or a free-standing imaging or diagnostic center)[3]	$95 co-pay	$50 co-pay

1 Not all covered services apply to out-of-pocket. Contact UnitedHealthcare for details.
2 The diagnostic radiology services require specialized equipment beyond standard X-ray equipment and must be performed by specialty trained or certified personnel. Examples include, but are not limited to, specialized scans, CT, SPECT, PET, MRI, MRA, nuclear studies, sonograms, diagnostic mammograms and interventional radiological procedures (angiogram and barium studies).
3 Other co-pays may apply.

Benefits Comparison: Medicare Advantage (MA) Preferred Provider Organization (PPO) Standard and Premium Plans

January 1, 2016 – December 31, 2016

	MA PPO – Standard UnitedHealthcare	MA PPO – Premium UnitedHealthcare
Behavioral Health	**You Pay**	**You Pay**
Mental Health and Substance Abuse Inpatient Facility	20% co-insurance per inpatient admission	20% co-insurance per inpatient admission
Mental Health and Substance Abuse Outpatient Visits	$30 co-pay Professional Individual & Group Therapy Visits $55 co-pay Professional Partial Hospitalization visits	$25 co-pay Professional Individual & Group Therapy Visits $50 co-pay Professional Partial Hospitalization visits
Dental	**You Pay**	**You Pay**
Dental and Oral Care Medicare covered	$30 per office visit co-pay for Medicare covered dental services	$25 per office visit co-pay for Medicare covered dental services
Vision	**You Pay**	**You Pay**
Routine Eye Exam NOTE: Limited to one eye exam every 12 months including refraction exam	$30 co-pay per office visit—limited to 1 annual eye exam; $125 eyewear benefit (glasses/frames or contact lenses) allowance every 24 months[1]	$25 co-pay per office visit—limited to 1 annual eye exam; $125 eyewear benefit (glasses/frames or contact lenses) allowance every 24 months[1]
Other Coverage	**You Pay**	**You Pay**
Hearing Services and Hearing Aids	$30 co-pay limited to one test every 12 months; $1,000 hearing aid allowance every 48 months	$25 co-pay limited to one test every 12 months; $1,000 hearing aid allowance every 48 months
Ambulance Services NOTE: “Land or air ambulance” to nearest facility to treat the condition	$50 co-pay	$50 co-pay
Urgent Care Services	$25 co-pay; waived if admitted to hospital within 24 hours for the same condition	$20 co-pay; waived if admitted to hospital within 24 hours for the same condition
Other Coverage	**You Pay**	**You Pay**
Home Health Care Services	$0 co-pay per visit	$0 co-pay per visit
Emergency Care	$50 co-pay; waived if admitted to hospital within 72 hours for the same condition	$50 co-pay; waived if admitted to hospital within 72 hours for the same condition
Skilled Nursing Facility Services Prior authorization required	$0 co-pay per day for days 1–20; $50 co-pay per day for days 21–100 for up to 100 days per benefit period (no prior hospital stay required)	$0 co-pay per day for days 1–10; $25 co-pay per day for days 11–100 for up to 100 days per benefit period (no prior hospital stay required)

[1] $0 co-pay for one pair of eyeglasses or contact lenses after cataract surgery.

Benefits Comparison: Medicare Advantage (MA) Preferred Provider Organization (PPO) Standard and Premium Plans

January 1, 2016 – December 31, 2016

	MA PPO – Standard UnitedHealthcare	MA PPO – Premium UnitedHealthcare
Other Coverage	**You Pay**	**You Pay**
Hospice Care	100% coverage; must receive care from a Medicare covered hospice facility; (no prior approval required). For services not related to the terminal condition member cost-shares may apply.	100% coverage; must receive care from a Medicare covered hospice facility; (no prior approval required). For services not related to the terminal condition member cost-shares may apply.
Durable Medical Equipment (DME) Prior approval required for certain DME.	20% coverage for Medicare covered items.	20% coverage for Medicare covered items.
Outpatient Acute Short-Term Rehabilitation Services • Physical Therapy • Speech Therapy • Occupational Therapy • Cardiac Therapy • Pulmonary Therapy	$25 co-pay per office visit for Medicare covered services.	$10 co-pay per office visit for Medicare covered services.
Chiropractic Care	Medicare covered: $18 co-pay per office visit; Routine Non-Medicare covered: $30 co-pay per office visit; limit of 20 visits per year.	Medicare covered: $18 co-pay per office visit; Routine Non-Medicare covered: $25 co-pay per office visit; limit of 20 visits per year.
Foot Care	Medicare covered: $30 co-pay per office visit; Routine Non-Medicare covered: $25 co-pay; limit of 6 visits per year.	Medicare covered: $25 co-pay per office visit; Routine Non-Medicare covered: $15 co-pay; limit of 6 visits per year.
Pharmacy	**You Pay**	**You Pay**
Select Generic Co-pay	$0 retail or mail order	$0 retail or mail order
Tier 1 Co-pay	$15 retail—31 day supply; $37.50 mail order—90-day supply	$15 retail—31 day supply; $37.50 mail order—90-day supply
Tier 2 Co-pay	$45 retail—31 day supply; $112.50 mail order—90-day supply	$45 retail—31 day supply; $112.50 mail order—90-day supply
Tier 3 Co-pay	$85 retail—31 day supply; $212.50 mail order—90- day supply	$85 retail—31 day supply; $212.50 mail order—90-day supply
Tier 4 Co-pay	$85 retail—31 day supply; $212.50 mail order— 90-day supply	$85 retail—31 day supply; $212.50 mail order—90-day supply

After your yearly true out-of-pocket (TROOP) cost reaches $4,850 for generic drugs, you will pay 5% coinsurance with a minimum co-pay of $2.95 and a maximum co-pay of $10.00 and for brand drugs you will pay 5% co-insurance with a minimum co-pay of $7.40 and a maximum co-pay of $40.00. You will continue to pay $0 for Select Generic Drugs listed in the formulary for UnitedHealthcare MA Members.

***NOTE:** While the co-pay amounts are not changing for 2016, you may want to check with UnitedHealthcare to see if the medications you are taking have changed tiers for 2016.*

Non-Medicare Advantage (MA) Plan Options

SHBP members who do not elect an MA Preferred Provider Organization (PPO) Plan Option and/or have covered family members who are not eligible for the MA PPO Plan can select a Non-MA option.

The 2016 Non-MA Plan Options (listed below) are designed to provide members with a choice of Plan Options that best meet their needs.

Blue Cross and Blue Shield of Georgia (BCBSGa)

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

UnitedHealthcare

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

Note: For BCBSGa and UnitedHealthcare, the pharmacy benefits will be administered by Express Scripts (ESI) and the Wellness benefits will be administered by Healthways.

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

Additional Options

The TRICARE Supplement will continue to be available for those members enrolled in TRICARE. See page 33 for additional information.

PeachCare for Kids® will continue to be available for those members enrolled in PeachCare for Kids. See page 34 for additional information.

Express Scripts administers the pharmacy benefits for members who choose BCBSGa and UnitedHealthcare. ESI provides benefits for retail prescription drug products, mail order, home delivery and specialty pharmacy services.

Healthways provides members with comprehensive well-being resources and incentive programs for BCBSGa and UnitedHealthcare. Healthways will also administer the 2016 action-based health incentives that will allow SHBP members and covered spouses to earn additional well-being incentive credits.

Understanding Your Plan Options For 2016

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

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

It is important to note that when you go to the doctor, you do not pay a co-pay. Instead, you pay the applicable deductible or co-insurance.

SHBP contributes HRA credits to your HRA account based on the HRA Plan Option and tier you enroll in. If you have unused credits in your HRA account from 2015, those credits will rollover to the next Plan Year as long as you remain enrolled in a SHBP Plan Option, excluding TRICARE Supplement. All unused 2015 well-being incentive credits will rollover to your 2016 HRA plan, or any other Plan Option in April 2016. No 2015 well-being incentives credits will be forfeited.

NOTE: There is a date limitation to how you may use the 2015 rollover credits for reimbursement. Only eligible medical expenses incurred after the rollover in April 2016 will qualify for reimbursement using the 2015 well-being incentive credit rollover funds. Expenses for services incurred between January - March are not eligible for reimbursement from 2015 rollover credits. However, until your 2015 credits roll over, your 2016 HRA credits funded by SHBP and any 2016 well-being incentive credits earned and available at the time claims are received by your medical claims administrator may be used for those expenses during this time period.

Plan Features:

- 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)
- You must meet separate in-network and out-of-network deductibles
- You must meet separate in-network and out-of-network out-of-pocket maximums
- After you meet your annual deductible, you pay a percentage of the cost of your covered expenses, called co-insurance
- You are not required to select a Primary Care Physician (PCP) or obtain referrals to a Specialist (SPC)
- The credits in your HRA account are used to help meet your deductibles and your out-of-pocket maximums
- 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 your well-being incentive credits 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 Programs (DM) 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 HRA account will be prorated. However, your deductible and co-insurance will not be prorated
- You and your covered spouse are eligible to earn up to 480 well-being incentive credits each by participating in the Healthways Well-Being program, Be Well SHBP.

NOTE: Pharmacy benefits are administered by Express Scripts and the Wellness benefits are administered by Healthways.

How the High Deductible Health Plan (HDHP) Works

The HDHP offers in-network and out-of-network benefits and provides access to a network of providers on a statewide and national basis across the United States. The HDHP has a low monthly premium. However, you must satisfy a high deductible that applies to all covered medical and pharmacy expenses (except preventive care). If you have You + child, You + spouse or You + family coverage, the entire family deductible NO LONGER has to be met before benefits are payable for an individual family member.

Effective, January 1, 2016, the Affordable Care Act (ACA) will limit the deductible and out-of-pocket maximum amounts to members enrolled in a coverage tier other than You (single). The You coverage tier (single) deductible and out-of-pocket maximum will now 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 covered 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 covered medical and pharmacy expenses will be paid at 100% for the Plan Year for that family member.

For example:
An individual that is covered under a family coverage tier, regardless of how many family members are in that tier, will have a maximum individual network deductible of $3,500 and a maximum individual network out-of-pocket of $6,450. The individual out-of-network deductible 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.

For 2016, UnitedHealthcare will match up to an additional 240 well-being incentive credits for members enrolled in an HDHP plan who complete certain wellness actions through Healthways. This 240 match is in addition to the 480 well-being incentive credits members can earn by completing certain wellness actions through Healthways. Spouses are not eligible for the additional 240 well-being incentive credits match from UnitedHealthcare.

Note: Before you can use well-being incentive credits members must meet a threshold ($1,300 – individual; $2,600 other tiers)

Also, you may qualify to establish a Health Savings Account (HSA) to set aside tax-free dollars to pay for eligible health care expenses now or in the future. HSAs typically earn interest and may even offer investment options.

Plan Features:

- You must meet separate in-network and out-of-network deductibles and out-of-pocket maximums
- The HDHP option pays 100% of covered services provided by in-network providers that are properly coded as “preventive care” within the meaning of the Affordable Care Act (ACA)
- You pay co-insurance after meeting the deductible for all covered medical and pharmacy expenses until the out-of-pocket maximum is met
- The medical and pharmacy out-of-pocket maximums are combined
- There are no co-pays
- You and your covered spouse are eligible to earn up to 480 well-being incentive credits each by participating in the Healthways well-being program Be Well SHBP.
- Before you can use well-being incentive credits, members must meet a threshold ($1,300 – individual; $2,600 other tiers)
- Certain drug costs are waived if SHBP is primary and you actively participate in one of the Disease Management Programs (DM) for diabetes, asthma, and/or coronary artery disease.

NOTE: Pharmacy benefits are administered by Express Scripts and the Wellness benefits are administered by Healthways.

IMPORTANT NOTE: Pharmacy benefits are subject to the deductible and benefits are not payable until the deductible is met.

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 SHBP HDHP and do not have other coverage through:
1) Your spouse's employer's plan,
2) Medicare, or
3) Medicaid

HSA Features:

- Must be enrolled in an HDHP
- The HSA cannot be used with an FSA
- Only the amount of the actual account balance is available for reimbursement
- The employee owns the account and keeps the account
- Investment options are available with a minimum balance and interest accrues on a tax-free basis
- Contributions can start, stop or change anytime
- Distributions cover qualified medical expenses as defined under Section 213(d) of the Internal
- Revenue Code and certain other expenses
- Tax form 1099 SA and 5498 are sent to employees for filing

How the Statewide Health Maintenance Organization (HMO) with Blue Cross and Blue Shield of Georgia (BCBSGa) 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. The HMO Plan Option pays 100% of covered services provided by in-network providers that are properly coded as "preventive care" within the meaning of the Affordable Care Act (ACA). 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.

Plan Features:

- There are co-pays with this plan for certain services
- Certain services are subject to a deductible and co-insurance (see the Comparison Benefit 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)
- Co-pays do not count toward your deductibles
- Co-pays do count toward your out-of-pocket maximum
- 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
- You and your covered spouse are eligible to earn up to 480 well-being incentive credits each by participating in the Healthways well-being program, Be Well SHBP

Members enrolled in UnitedHealthcare are eligible to earn up to an additional 240 well-being incentive credits match when completing certain wellness actions through Healthways. Spouses are not eligible for the additional 240 well-being incentive credits match from UnitedHealthcare.

NOTE: For Blue Cross and Blue Shield of Georgia (BCBSGa) and UnitedHealthcare, the pharmacy benefits are administered by Express Scripts and the Wellness benefits are administered by Healthways.

**May be used with a general, limited purpose FSA. For more details, please contact your FSA administrator.*

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) eligible employees who **live or work** in one of the listed 27 counties within the Metro Atlanta Service Area.

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

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

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

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

Plan Features:

- This is a co-pay only option
- There are no deductibles or co-insurances
- The medical and pharmacy out-of-pocket maximums are combined.
- You and your covered spouse can each earn a $240 Visa gift card for the completion of specific KP wellness activities.

Photo credit: Georgia Department of Economic Development

Benefits Comparison: Non-Medicare Advantage (MA) Plans

Photo credit: Georgia Department of Economic Development

Please read the Benefits Comparison table 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 included with your enrollment information or online at www.dch.georgia.gov/shbp.

Benefits Comparison: HRA Plans

January 1, 2016 – December 31, 2016

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

Benefits Comparison: HMO, HDHP Plans

January 1, 2016 – December 31, 2016

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

Benefits Comparison: HRA Plans

January 1, 2016 – December 31, 2016

	BCBSGa Gold HRA Option		BCBSGa Silver HRA Option		BCBSGa Bronze HRA Option	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Physicians' Services	**The Plan Pays**		**The Plan Pays**		**The Plan Pays**	
Physician Services for Emergency Care	85% coverage; subject to deductible		80% coverage; subject to deductible		75% coverage; subject to deductible	
Allergy Shots and Serum	85% coverage; subject to deductible	60% coverage; subject to deductible	80% coverage; subject to deductible	60% coverage; subject to deductible	75% coverage; subject to deductible	60% coverage; subject to deductible
Outpatient Surgery/ Services • When billed as an office visit	85% coverage; subject to deductible	60% coverage; subject to deductible	80% coverage; subject to deductible	60% coverage; subject to deductible	75% coverage; subject to deductible	60% coverage; subject to deductible
Outpatient Surgery/ Services • When billed as an outpatient surgery at a facility	85% coverage; subject to deductible	60% coverage; subject to deductible	80% coverage; subject to deductible	60% coverage; subject to deductible	75% coverage; subject to deductible	60% coverage; subject to deductible
Hospital Services	**The Plan Pays**		**The Plan Pays**		**The Plan Pays**	
Inpatient Services • Inpatient care, delivery and inpatient short-term acute rehabilitation services	85% coverage; subject to deductible	60% coverage; subject to deductible	80% coverage; subject to deductible	60% coverage; subject to deductible	75% coverage; subject to deductible	60% coverage; subject to deductible
Inpatient Services • Well newborn care	85% coverage; subject to deductible	60% coverage; subject to deductible	80% coverage; subject to deductible	60% coverage; subject to deductible	75% coverage; subject to deductible	60% coverage; subject to deductible
Outpatient Surgery/ Services • At a hospital or other facility	85% coverage; subject to deductible	60% coverage; subject to deductible	80% coverage; subject to deductible	60% coverage; subject to deductible	75% coverage; subject to deductible	60% coverage; subject to deductible
Hospital Emergency Room Care • Treatment of an emergency medical condition or injury	85% coverage; subject to in-network deductible		80% coverage; subject to in-network deductible		75% coverage; subject to in-network deductible	
Outpatient Testing, Lab, etc.	**The Plan Pays**		**The Plan Pays**		**The Plan Pays**	
Non-Routine Laboratory; X-Rays; Diagnostic Tests; Injections • Including medications covered under medical benefits--for the treatment of an illness or injury	85% coverage; subject to deductible	60% coverage; subject to deductible	80% coverage; subject to deductible	60% coverage; subject to deductible	75% coverage; subject to deductible	60% coverage; subject to deductible
Complex Radiology Testing MRIs, CTs, PET and Nuclear Medicine	85% coverage; subject to deductible	60% coverage; subject to deductible	80% coverage; subject to deductible	60% coverage; subject to deductible	75% coverage; subject to deductible	60% coverage; subject to deductible

Benefits Comparison: HMO, HDHP Plans

January 1, 2016 – December 31, 2016

	BCBSGa /UnitedHealthcare Statewide HMO Option	UnitedHealthcare HDHP Option		KP Regional HMO Option
	In-Network only	In-Network	Out-of-Net-work	In-Network only
Physicians' Services	**The Plan Pays**	**The Plan Pays**		**The Plan Pays**
Physician Services for Emergency Room Care	100% coverage	70% coverage; subject to in-network deductible		100% coverage
Allergy Shots and Serum	100% after $35 PCP co-pay $45 SPC co-pay	70% coverage; subject to deductible	50% coverage; subject to deductible	100% after $35 PCP co-pay $45 SPC co-pay
Outpatient Surgery/Services • When billed as an office visit	100% after $35 PCP co-pay $45 SPC co-pay	70% coverage; subject to deductible	50% coverage; subject to deductible	100% after $35 PCP co-pay $45 SPC co-pay
Outpatient Surgery/Services • When billed as an outpatient surgery at a facility	80% coverage; subject to deductible	70% coverage; subject to deductible	50% coverage; subject to deductible	100% coverage after $100 co-pay
Hospital Services	**The Plan Pays**	**The Plan Pays**		**The Plan Pays**
Inpatient Services • Inpatient care, delivery and inpatient short-term acute rehabilitation services	80% coverage; subject to deductible	70% coverage; subject to deductible	50% coverage; subject to deductible	100% coverage after $250 co-pay
Inpatient Services • Well newborn care	100% coverage; not subject to deductible	70% coverage; subject to deductible	50% coverage; subject to deductible	100% coverage
Outpatient Surgery/Services • At a hospital or other facility	80% coverage; subject to deductible	70% coverage; subject to deductible	50% coverage; subject to deductible	100% coverage after $100 co-pay
Hospital Emergency Room Care • Treatment of an emergency medical condition or injury	100% coverage after $150 co-pay, if admitted co-pay waived	70% coverage; subject to in-network deductible		100% coverage after $150 co-pay, if admitted co-pay waived
Outpatient Testing, Lab, etc.	**The Plan Pays**	**The Plan Pays**		**The Plan Pays**
Non-Routine Laboratory; X-Rays; Diagnostic Tests; Injections • Including medications covered under medical benefits--for the treatment of an illness or injury	80% coverage; subject to deductible	70% coverage; subject to deductible	50% coverage; subject to deductible	100% coverage at KP or contracted facility $100 co-pay at outpatient hospital facility
Complex Radiology Testing MRIs, CTs, PET and Nuclear Medicine	80% coverage; subject to deductible	70% coverage; subject to deductible	50% coverage; subject to deductible	$45 co-pay at KP or contracted free-standing imaging center $100 co-pay at outpatient hospital facility

Benefits Comparison: HRA Plans

January 1, 2016 – December 31, 2016

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

Benefits Comparison: HMO, HDHP Plans

January 1, 2016 – December 31, 2016

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

Benefits Comparison: HRA Plans

January 1, 2016 – December 31, 2016

	BCBSGa Gold HRA Option		BCBSGa Silver HRA Option		BCBSGa Bronze HRA Option	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Other Coverage	**The Plan Pays**		**The Plan Pays**		**The Plan Pays**	
Applied Behavior Analysis NOTE: Requires prior approval, only covered for treatment for autism spectrum disorders 0 though age 10	85% coverage not subject to deductible $35,000 benefit maximum per Plan Year		80% coverage not subject to deductible $35,000 benefit maximum per Plan Year		75% coverage not subject to deductible $35,000 benefit maximum per Plan Year	
Urgent Care Services	85% coverage; subject to deductible	60% coverage; subject to deductible	80% coverage; subject to deductible	60% coverage; subject to deductible	75% coverage; subject to deductible	60% coverage; subject to deductible
Home Health Care Services NOTE: Prior approval required.	85% coverage; subject to deductible	60% coverage; subject to deductible	80% coverage; subject to deductible	60% coverage; subject to deductible	75% coverage; subject to deductible	60% coverage; subject to deductible
Skilled Nursing Facility Services NOTE: Prior approval required.	85% coverage; up to 120 days per Plan Year; subject to deductible	Not covered	80% coverage; up to 120 days per Plan Year; subject to deductible	Not covered	75% coverage; up to 120 days per Plan Year; subject to deductible	Not covered
Hospice Care NOTE: Prior approval required.	85% coverage; subject to deductible	60% coverage; subject to deductible	80% coverage; subject to deductible	60% coverage; subject to deductible	75% coverage; subject to deductible	60% coverage; subject to deductible
Durable Medical Equipment (DME) -- Rental or purchase NOTE: Prior approval required for certain DME.	85% coverage; subject to deductible	60% coverage; subject to deductible	80% coverage; subject to deductible	60% coverage; subject to deductible	75% coverage; subject to deductible	60% coverage; subject to deductible
Transplant Services NOTE: Prior approval required.	Contact the Medical Claims Administrator for coverage details.					

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

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

Benefits Comparison: HMO, HDHP Plans

January 1, 2016 – December 31, 2016

	BCBSGa/UnitedHealthcare Statewide HMO Option	UnitedHealthcare HDHP Option		KP Regional HMO Option
	In-Network Only	In-Network	Out-of-Network	In-Network Only
Other Coverage	**The Plan Pays**	**The Plan Pays**		**The Plan Pays**
Applied Behavior Analysis NOTE: Requires prior approval, only covered for treatment for autism spectrum disorders 0 though age 10	100% after $35 PCP co-pay $45 SPC co-pay $35,000 benefit maximum per Plan Year	70% coverage; subject to deductible $35,000 benefit maximum per Plan Year		100% after $35 PCP co-pay $45 SPC co-pay $35,000 benefit maximum per Plan Year
Urgent Care Services	100% after $35 co-pay	70% coverage; subject to deductible	50% coverage; subject to deductible	100% after $35 co-pay
Home Health Care Services NOTE: Prior approval required	100% coverage	70% coverage; subject to deductible	50% coverage; subject to deductible	100% coverage
Skilled Nursing Facility Services NOTE: Prior approval required	100% coverage; up to 120 days per Plan Year	70% coverage; up to 120 days per Plan Year; subject to deductible	Not Covered	100% coverage;
Hospice Care NOTE: Prior approval required	100% coverage	70% coverage; subject to deductible	50% coverage; subject to deductible	100% coverage
Durable Medical Equipment (DME) - Rental or purchase NOTE: Prior approval required for certain DME	100% coverage	70% coverage; subject to deductible	50% coverage; subject to deductible	100% coverage
Transplant Services NOTE: Prior approval required	Contact the Medical Claim Administrator for coverage details			

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

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

Benefits Comparison: HRA Pharmacy

January 1, 2016 – December 31, 2016

	Gold HRA Option		Silver HRA Option		Bronze HRA Option	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Other Coverage	**The Plan Pays**		**The Plan Pays**		**The Plan Pays**	
Tier 1 Co-insurance NOTE: per 31-day maximum supply	15% ($20 min/$50 max); not subject to deductible		15% ($20 min/$50 max); not subject to deductible		15% ($20 min/$50 max); not subject to deductible	
Tier 2 Co-insurance Preferred Brand NOTE: per 31-day maximum supply	25% ($50 min/$80 max); not subject to deductible		25% ($50 min/$80 max); not subject to deductible		25% ($50 min/$80 max); not subject to deductible	
Tier 3 Co-insurance Non-Preferred Brand NOTE: per 31-day maximum supply	25% ($80 min/$125 max); not subject to deductible		25% ($80 min/$125 max); not subject to deductible		25% ($80 min/$125 max); not subject to deductible	
Participating 90-day Voluntary Mail Order OR Retail 90-day Network	Tier 1–15% ($50 min/$125 max) Tier 2–25% ($125 min/$200 max) Tier 3–25% ($200 min/$313 max)		Tier 1–15% ($50 min/$125 max) Tier 2–25% ($125 min/$200 max) Tier 3–25% ($200 min/$313 max)		Tier 1–15% ($50 min/$120 max) Tier 2–25% ($125 min/$200 max) Tier 3–25% ($200 min/$313 max)	

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

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

Benefits Comparison: HMO, HDHP Pharmacy

January 1, 2016 – December 31, 2016

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

NOTE: Co-pay amounts you pay do not go toward the deductible; however they do go toward the out-of-pocket maximum.
**NOTE: For HDHP out-of-network, pharmacy expenses are paid at 70 percent of the contracted rate after the deductible has been satisfied.*

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

Alternative Coverage

TRICARE Supplement for Eligible Military Members

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

The TRICARE Supplement Plan is an alternative to State Health Benefit Plan (SHBP) coverage that is offered to members and dependents who are eligible for SHBP coverage and enrolled in TRICARE. The TRICARE Supplement Plan is not sponsored by the SHBP, the Georgia Department of Community Health (DCH) or any employer. The TRICARE Supplement Plan is sponsored by the Government Employees Association, Inc. (GEA) and is administered by Selman & Company. In general, to be eligible, the members and dependents must each be under age 65, ineligible for Medicare and registered in the Defense Enrollment Eligibility Reporting System (DEERS).

If you enroll in the TRICARE Supplement and are not eligible, your election will be changed to the default option, Blue Cross and Blue Shield of Georgia (BCBSGa) Bronze Health Reimbursement Arrangement (HRA), which includes the Tobacco Surcharge if you were paying for it prior to enrollment in the TRICARE Supplement. For active members, the payroll location will be notified to collect the additional premiums.

Who is eligible for enrollment in the TRICARE Supplement Plan?

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

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

Points to consider if you elect TRICARE Supplement Plan coverage

- Effective January 1, 2016, TRICARE will become your primary coverage
- TRICARE Supplement Plan will become the secondary coverage
- The eligibility rules and benefits described in
- the TRICARE Supplement Plan will apply:
  - Unmarried adult children under the age of 26 who are no longer eligible for regular TRICARE must be enrolled in TRICARE Young Adult (TYA) through
  - TRICARE before enrolling in the TRICARE Supplement Plan
  - Unmarried children under the age of 21 or 23, if a full-time student who are no longer eligible for regular TRICARE, must be enrolled in TYA through TRICARE before enrolling in the TRICARE Supplement Plan.
- Tobacco Surcharge will not apply
- COBRA rights will not apply
- If you or your dependents lose eligibility for SHBP coverage while you are enrolled in the TRICARE Supplement Plan, you will be offered a portability feature by Selman & Company, administrator of the TRICARE Supplement
- Loss of eligibility for the TRICARE Supplement Plan is a Qualifying Event (QE). If you continue to be eligible for coverage under the SHBP, you may enroll in an SHBP option outside of the Open Enrollment period if you make a request within 31 days of losing eligibility for the TRICARE Supplement Plan.

TRICARE Supplement (cont.)

- Attainment of age 65 and eligibility for Medicare causes a loss of eligibility for TRICARE Supplement Plan coverage. This is a Qualifying Event (QE) and retirees must make a request within 31 days to re-enroll in an SHBP coverage option. If no request is made, your election will be changed to the default option, Blue Cross and Blue Shield of Georgia (BCBSGa) Bronze Health Reimbursement Arrangement (HRA) and/or UnitedHealthcare MA PPO Standard Plan (if applicable)
- Retirees who elect TRICARE Supplement Plan coverage may discontinue TRICARE Supplement Plan coverage and re-enroll in SHBP coverage in the future as long as they maintain continuous coverage with either the TRICARE Supplement Plan or SHBP coverage and make their change on the SHBP Member Portal during the Retiree Option Change Period (ROCP).

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.dch.georgia.gov/shbp.

PeachCare for Kids®

As state or public school employees, you could be eligible to enroll your children in PeachCare for Kids. Visit www.peachcare.org or call 877-427-3224 for information.

Photo credit: Georgia Department of Economic Development

2016 Wellness

Wellness 2016 for Blue Cross and Blue Shield of Georgia (BCBSGa) and UnitedHealthcare Non-Medicare Advantage (MA) Members

The State Health Benefit Plan (SHBP) is excited to continue working with our Wellness partner, Healthways. If you elect BCBSGa or UnitedHealthcare coverage, you and your covered spouse have access to the Healthways Well-Being program, 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, Healthways can help. The program is confidential, voluntary and offered at no additional cost to you.

The types of support you receive includes: the Healthways Well-Being Assessment® questionnaire; an online interactive well-being plan; 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 Healthways program, visit the program site at www.BeWellSHBP.com.

Participate and Earn Well-Being Incentive Credits

When you participate in the Healthways Well-Being program, you and your covered spouse are each eligible to earn up to 480 well-being incentive credits to offset eligible medical expenses.* The earlier you complete these actions, the earlier you will receive your credits and will be able to start using them.

Depending on the Plan Option you select, the well-being incentive credits you will earn work a little differently. Here's how:

How Well-being Incentive Credits Work With Each Plan Option:

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

* Refer to the chart on the next page to learn how to earn well-being incentive credits.

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

SHBP will continue to fund HRA credits to your HRA to provide first dollar coverage for those covered services requiring a deductible/co-insurance and pharmacy co-insurance. The HRA credits are used to reduce the out-of-pocket amount you must pay. When you complete a health action, well-being incentive credits will be placed into your incentive account within 30 days. After satisfying your deductible, you will pay your co-insurance amount for covered services until you reach your out-of-pocket maximum. If you do not use all your HRA credits, the HRA credits will roll over as long as you remain continuously enrolled in a SHBP Plan Option.

You and/or your covered spouse can earn additional well-being incentive credits for your HRA for the completion of certain health actions. To earn these HRA well-being incentive credits, complete the requirements shown in the following chart between January 1 and December 15, 2016.

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

You and/or your covered spouse can continue to earn well-being incentive credits into an incentive account for the completion of certain health actions. Incentive accounts house well-being incentive credits tied to the HMO Plan Options. These well-being incentive credits can be used to help you offset certain health care costs such as co-pays and deductibles. When you complete a health action, well-being incentive credits will be placed into your incentive account within 30 days. To earn these credits, complete the requirements shown in the following chart between January 1 and December 15, 2016.

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

You and/or your covered spouse can continue to earn well-being incentive credits into an incentive account for the completion of certain health actions. Incentive accounts house Well-being incentive credits tied to the HDHP Option. These well-being incentive credits can be used to help you offset certain health care costs such as deductibles and co-insurance. When you complete a health action, well-being incentive credits will be placed into your incentive account within 30 days. **IMPORTANT**: Before the earned well-being incentive credits in the incentive account can be used, you will need to pay for covered services until the following amounts have been paid toward your deductible:

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

Note: The above amounts reflect a portion of the total required deductible.
To earn these well-being incentive credits, complete the requirements shown in the following chart between January 1 and December 15, 2016.

If you select BCBSGa or UnitedHealthcare (non-Medicare Advantage), you and your covered spouse are eligible to earn up to 480 well-being incentive credits by participating in the Healthways well-being program called Be Well SHBP*. As you earn credits, SHBP will contribute them to your BCBSGa My Incentive Account (MIA) or your UnitedHealthcare Health Incentive Account (HIA) to offset eligible medical expenses.

Go to www.BeWellSHBP.com and complete the well-being actions below with Healthways between January 1 and December 15, 2016:

	What to Do	What You will Earn*
1.	**Assess Your Health** Complete a Healthways Well-Being Assessment® (WBA) that takes about 20 minutes.	***Complete BOTH and earn 240 well-being incentive credits***
2	**Know Your Numbers** Complete a biometric screening (body mass index, blood pressure, cholesterol, glucose). • At an SHBP-sponsored screening event or, • With your Physician using the Healthways 2016 Physician Screening Form	
3.	**Take Action** Complete your WBA, then use the tools that make sense to you. **Phone Coaching** Get support to eat better, lose weight, stress less, get active, feel happier, or quit tobacco with a Healthways well-being coach. • Complete your WBA and actively engage in telephonic coaching and earn 240 well–being incentive credits. **Online Resources** • Complete your WBA and record five online well-being activities using the same tracker within a calendar month and earn 40 well-being incentive credits. Sample activities: track exercise five times, record daily steps five times, track food five times. You can earn these online resource credits up to 6 times for a total of 240 credits.	**Earn up to 240 well-being incentive credits**

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

Rollover Credits: Regardless of what Plan Option you select, all unused well-being incentive credits earned in 2015 will automatically roll over to your 2016 Plan Option. SHBP will deposit your unused credits in the incentive account associated with your 2016 plan selection in April 2016.

*Healthways 2016 incentives do not apply to Kaiser Permanente or the Medicare Advantage Options. See the Kaiser Permanente Rollover Account (KPRA) program description within this guide for details.

Reminder: You and your spouse (if covered) may appeal the well-being incentive credits applied if the credits are less than you believe should have been awarded to you or your spouse. Wellness appeals for the 2015 well-being incentive credits must be filed by February 1, 2016. Please see the Summary Plan Description (SPD) for additional details.

Changing to the Medicare Advantage (MA) Plan Option from another Plan Option

- Any unused wellness credits will remain in your Health Reimbursement Arrangement (HRA), Health Incentive Account (HIA), My Incentive Account (MIA) or Kaiser Permanente Rollover Account (KPRA) for a six-month run out period, to allow for prior year's claims processing
- If you have a balance of $100 or more in your HRA, HIA, MIA or KPRA after being enrolled in MA for at least six months, an individual Retiree Reimbursement Account (RRA) will be set up by UnitedHealthcare
- UnitedHealthcare will reimburse you for MA co-pays or co-insurance out-of-pocket expenses to the maximum balance in the RRA

Wellness 2016 for Kaiser Permanente (KP)

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 Total Health Assessment, biometric screenings, online and onsite healthy living classes. To learn more about the services and programs, visit my.kp.org/shbp.

Kaiser Permanente Rollover Account (KPRA)

The KPRA will be available to members enrolling with Kaiser Permanente that have unused well-being incentive credits earned previously while participating in SHBP's wellness program (administered by Healthways, SHBP's wellness vendor). With the KPRA, members will be able to use those unused credits for eligible medical expenses incurred after April 2016 while insured under the KP Regional HMO plan.

If you have questions regarding your KPRA, contact KPRA customer service after April 2016 at 877-761-3399 or visit www.kp.org/healthpayment.

Note: Members that were enrolled in another SHBP Plan Option during 2015 with unused well-being incentive credits can enroll in KP during 2016 OE and their unused credits will roll into a Kaiser Permanente Rollover Account (KPRA). The balance will rollover in April 2016. If you terminate your coverage with SHBP, any unused KPRA credits will be forfeited.

Photo credit: Georgia Department of Economic Development

Wellness - 2016 Kaiser Permanente

Earn up to $480 and feel the benefits of taking care of your health!

Simply sign-up for the Kaiser Permanente Wellness Program at my.kp.org/shbp and make sure you are up-to-date on all four of the activities listed below. Each member (member and covered spouse) who satisfies the Kaiser Permanente Wellness Program requirements will receive a $240 Visa gift card ($480 per household)! Use your wellness incentive to further embrace your Total Health.

Getting your reward is easy and there is no specific order in which these four wellness activities must be completed! Just sign on to my.kp.org/shbp to accept your Wellness Program agreement, which is required for reward eligibility. For details or questions go to my.kp.org/shbp or call 1-866-300-9867.

	What to Do	What You will Earn*
1.	**Take Your Total Health Assessment:** Complete your 2016 Kaiser Permanente on-line Total Health Assessment (THA). The questionnaire is confidential and only takes about 20 minutes.	***How will YOU use your $240 Wellness Incentive reward?*** ***Complete all four activities and earn a Visa Gift Card worth $240.*** • Pay for co-pays and prescription medications for the entire year • Relieve stress with quarterly massages • Take a nice weekend hiking trip in the mountains • Splurge on new work-out clothes or walking shoes • Stock up on healthy foods at the grocery store ***Both members and covered spouse are eligible to earn the incentive for a total of $480 per household.***
2	**Know Your Numbers** Complete a Biometric Screening at a Kaiser Permanente Medical Office, or by a Kaiser Permanente clinician at a worksite wellness screening event. ONLY those screenings performed by Kaiser Permanente are eligible for the reward.	
3.	**Get Yourself Screened:** Complete an age and gender appropriate preventive screening for breast, cervical, or colorectal cancer.	
	Take an Online Course: Complete one online Healthy Lifestyle Program (HLP)	

Tobacco Policies

Tobacco Cessation

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

Tobacco Cessation Medications

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

Tobacco Surcharge

Tobacco surcharges are included in all SHBP options (except for the Medicare Advantage Plan Options and TRICARE Supplement). These surcharges are intended to promote tobacco cessation and use of the Tobacco Cessation Telephonic Coaching Programs. Please go to: www.dch.georgia.gov/shbp-plan-documents to access the tobacco surcharge removal policies.These policies allow you to have the tobacco surcharge removed by completing the 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 2016 by completing the Tobacco Surcharge Removal Requirements in the Tobacco Users Cessation Policies for BCBSGa, UnitedHealthcare and KP at: http://dch.georgia.gov/shbp-plan-surcharges.

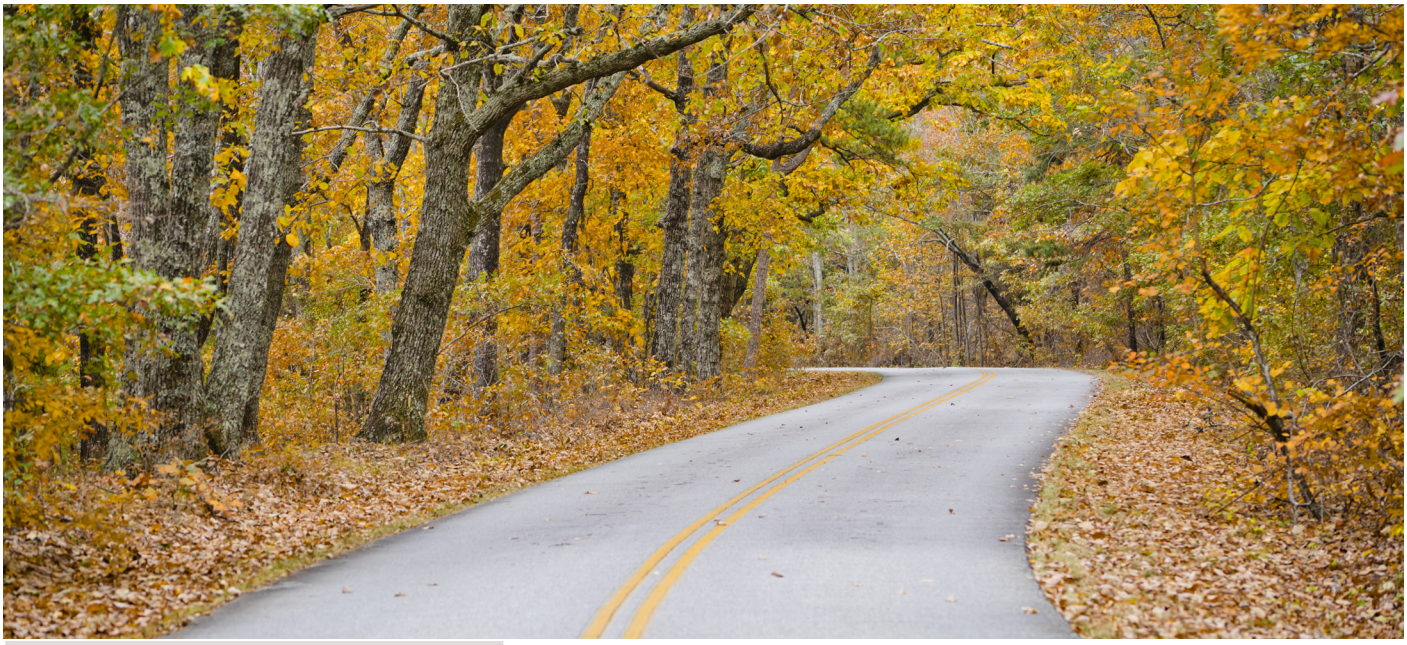

Photo credit: Georgia Department of Economic Development

Legal Notices

About the Following Notices

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

Penalties for Misrepresentation

If a SHBP participant misrepresents eligibility information when applying for coverage during change of coverage or when filing for benefits, the SHBP may take adverse action against the participants, including but not limited to terminating coverage (for the participant and his or her dependents) or imposing liability to the SHBP for fraud for 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/Provider (PCP). You have the right to designate any PCP who participates in the Claims Administrator's network, and who is available to accept you or your family members. For children, you may also designate a pediatrician as the PCP. For information on how to select a PCP, and for a list of participating PCPs, 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 able to enroll 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) your other health insurance coverage ends. However, you must request enrollment within 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 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 the SHBP Member Services Center at 800-610-1863 or contact your Benefit Coordinator/Payroll Location.

Legal Notices (cont.)

Women's Health and Cancer Rights Act of 1998

The Plan complies with the Women's Health and Cancer Rights Act of 1998. Mastectomy, including reconstructive surgery, is covered the same as other surgery 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 asymmetrical 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 the Plan, call the telephone number on the back of your Identification Card.

Newborns' and Mothers' Health Protection Act of 1996

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

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

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT NOTICE OF INFORMATION PRIVACY PRACTICES

Georgia Department of Community Health

State Health Benefit Plan Notice of Information Privacy Practices

Revised August 4, 2015

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

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

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

Plan "Enrollment Information" and "Claims Information" are Used in Order to Administer the Plan. PHI includes two kinds of information,

Legal Notices (cont.)

"Enrollment Information" and "Claims Information." "Enrollment Information" includes, but is not limited to, the following types of information regarding your plan enrollment: (1) your name, address, email address, social security number and all information that validates you (and/or your Spouse and Dependents) are eligible or enrolled in the Plan; (2) your Plan enrollment choice; (3) how much you pay for premiums; and (4) other health insurance you may have in effect. There are certain types of "Enrollment Information" which may be supplied to the Plan by you or your personal representative, your employer, other Plan vendors or other governmental agencies that may provide other benefits to you. This "Enrollment Information" is the only kind of PHI your employer is allowed to obtain. Your employer is prohibited by law from using this information for any purpose other than assisting with Plan enrollment. "Claims Information" includes information your health care providers submit to the Plan. For example, claims information may include medical bills, diagnoses, statements, x-rays or lab test results. It also includes information you may submit or communicate directly to the Plan, such as health questionnaires, biometric screening results, enrollment forms, leave forms, letters and/or telephone calls. Lastly, it includes information about you that may be created by the Plan. For example, it may include payment statements and/or other financial transactions related to your health care providers.

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

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

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

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

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

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

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

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

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

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

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

Legal Notices (cont.)

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

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

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

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

Information about Eligibility for the Plan and to Improve Plan Administration: The Plan may give PHI to other government agencies that may provide you benefits (such as state retirement systems) in order to get information about your eligibility for the Plan and to improve administration of the Plan.

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.dch.georgia.gov/shbp. If you think your HIPAA privacy rights may have been violated, you may file a complaint. You may file the complaint with the Plan and/or the U.S. Department of Health & Human Services, Office of Civil Rights, Region IV. You will never be penalized by the Plan or your employer for filing a complaint.

Legal Notices (cont.)

Address to File HIPAA Complaints:

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

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

For more information about this Notice, contact:

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

MENTAL HEALTH PARITY AND ADDICTION EQUITY ACT OPT-OUT NOTICE

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

Date: August 4, 2015

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

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

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

The exemption from these federal requirements will be in effect for the plan year starting January 1, 2016 and ending December 31, 2016. The election may be renewed for subsequent plan years.

Important Notice from State Health Benefit Plan (SHBP)

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

Important Notice from the Department of Community Health about Your 2016 Prescription Drug Coverage under the State Health Benefit Plan and Medicare for Plan Year: January 1 – December 31, 2016

Please read this notice carefully and keep it where you can find it. This notice has information about your current Prescription Drug coverage with the State Health Benefit Plan (SHBP) and about your options under Medicare's Prescription Drug coverage.

This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare Prescription Drug coverage in your area. Information about where you can get help to make decisions about your Prescription Drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's Prescription Drug coverage:

1. Medicare Prescription Drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers Prescription Drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. The Department of Community Health has determined that the Prescription Drug coverage offered under SHBP is, on average for all plan participants, expected to pay out as much as standard Medicare Prescription Drug coverage pays and is, therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th. However, if you lose your current creditable Prescription Drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period ("SEP") to join a Medicare drug plan.

What Happens To Your Current Coverage If You Decide to Join A Medicare Part D Drug Plan?

If you decide to join a Medicare drug plan, your current SHBP coverage will be affected. If you join a Medicare drug plan and do not terminate your SHBP coverage, SHBP will coordinate Benefits with the Medicare drug plan coverage the month following receipt of the notice. You should send a copy of your notice to SHBP at: P.O. Box 1990, Atlanta, GA 30301-1990.

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

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with SHBP and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go 19 months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare Prescription Drug coverage. In addition, if you don't join within 63

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

continuous days after your current coverage ends, you may have to wait until the following October to join.

For more Information About This Notice Or Your Current Prescription Drug Coverage, contact the SHBP Member Services Center at 800-610-1863 **Note: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through SHBP changes. You also may request a copy of this notice at any time.**

For More Information about Your Options Under Medicare Prescription Drug Coverage

More detailed information about Medicare plans that offer Prescription Drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans. For more information about Medicare Prescription Drug coverage, visit: www.medicare.gov

Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help. Call 1-800-MEDICARE at: 1-800-633-4227 (TTY 1-877-486-2048).

If you have limited income and resources, extra help paying for Medicare Prescription Drug coverage is available. For information about this extra help, visit Social Security on the web at: www.socialsecurity.gov or call at: 1-800-772-1213 (TTY: 1-800-325-0778).

REMEMBER: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

From: January 1, 2016 **To:** December 31, 2016
Date: August 4, 2015

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: http://dch.georgia.gov/shbp-plan-documents. To request a paper copy, you may call the SHBP Member Services Center 1-800-610-1863.

Georgia Law Section 33-30-13 Notice:

Member premiums for the HMO and HDHP options reflect new plan designs and discounts. Some members will experience premium increases as a result of their choices for 2016, while some will experience premium decreases. Since some members will experience a premium increase, DCH provides the following notice: "SHBP actuaries have determined that the total cost of coverage (which includes the cost paid by the State and the cost paid by members) under all options is .04% higher than it would be if the Affordable Care Act provisions that take place in 2016 did not apply."

Through effective planning, purchasing and oversight, the Georgia Department of Community Health (DCH) provides access to affordable, quality health care to millions of Georgians, including some of the state's underserved and most vulnerable populations. DCH is responsible for Medicaid and PeachCare for Kids®, the State Health Benefit Plan, Healthcare Facility Regulation and Health Information Technology in Georgia. Clyde L. Reese III, Esq., serves as Commissioner for the Georgia Department of Health.

To learn more about DCH and its dedication to A Healthy Georgia, visit www.dch.georgia.gov.

Photo credit: Georgia Department of Economic Development

Website for the Annual Retiree Option Change Period Available
October 19 at 12:00 a.m. through November 6 at 11:59 p.m. ET

For Plan Coverage effective
January 1, 2016 – December 31, 2016

The material in this booklet is for informational purposes only and is not a contract. It is intended only to highlight principal benefits of the 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) option, the Plan Documents including the SHBP regulations, are the Summary Plan Descriptions, Evidence of Coverage documents and reimbursement guidelines of the vendors. The Plan Documents for MA are the Evidence of Coverage (EOC) and the Rx Certificate of Coverage. It is the responsibility of each member, active or retired, to read the plan documents to fully understand how that option pays benefits. Availability of SHBP options may change based on federal or state law changes or as approved by the Board of Community Health. Premiums for SHBP options are established by the DCH Board and may be changed at any time by Board Resolutions subject to advance notice

Photo credit: Georgia Department of Economic Development

SHBP

State Health Benefit Plan

A Division of the Georgia Department of Community Health