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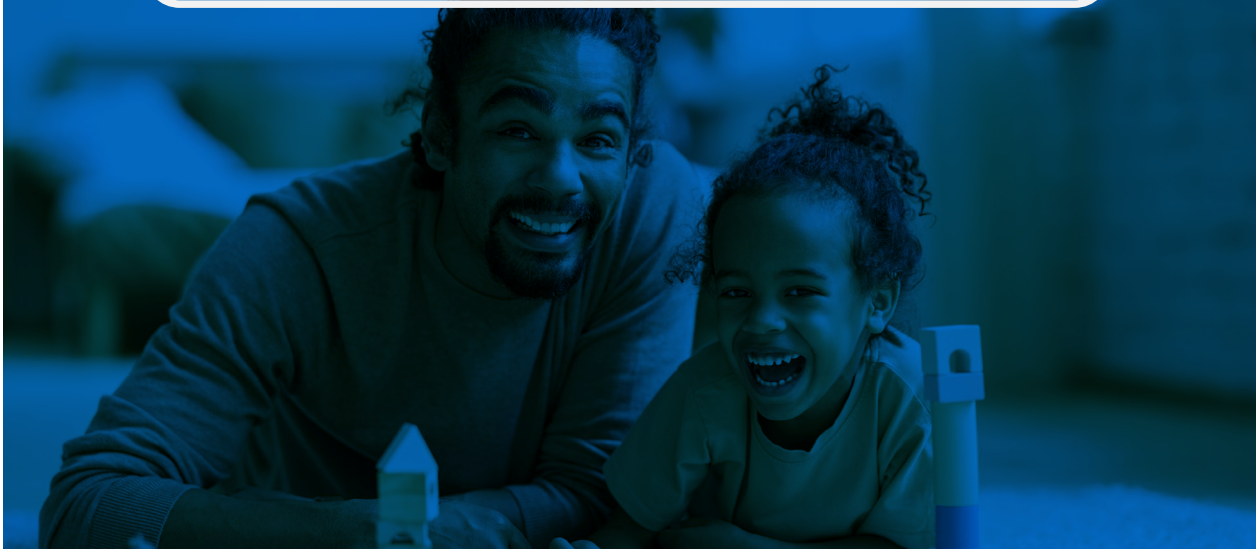
SHBP
State Health Benefit Plan
A Division of the Georgia Department of Community Health

MY 2024

SHBP ACTIVE MEMBER DECISION GUIDE

OPEN ENROLLMENT

OCTOBER 16 - NOVEMBER 3, 2023



STATE HEALTH BENEFIT PLAN RESOURCES/CONTACT INFORMATION

Anthem Blue Cross and Blue Shield (Anthem)		
Member Services: Monday - Friday, 8 a.m. - 8 p.m. ET	855-641-4862 (TTY 711)	anthem.com/shbp
NurseLine (24 hours per day/7 days per week)	866-787-6361	
Fraud Hotline: Monday - Friday, 8 a.m. - 8 p.m. ET	855-641-4862	
Kaiser Permanente (KP)		
Member Services: Monday - Friday, 7 a.m. - 7 p.m. ET	855-512-5997 (TTY 711)	my.kp.org/shbp
Nurse Advice and Appointment Scheduling (24 hours per day/7 days per week)	404-365-0966	
Prescription Help: Monday - Friday, 7 a.m. - 9 p.m. ET, Saturday and Sunday, 9 a.m. - 6 p.m. ET	404-365-0966	
Wellness Program Customer Service: Monday - Friday (except holidays), 11 a.m. - 8 p.m. ET	866-300-9867	
Fraud Hotline: Monday - Friday, 7 a.m. - 7 p.m. ET	855-512-5997	
Kaiser Permanente Rollover Account (KPRA) Customer Service Monday - Friday (except holidays), 11 a.m. - 8 p.m. ET	877-761-3399	kp.org/healthpayment
UnitedHealthcare		
Member Services: Monday - Friday, 8 a.m. - 8 p.m. ET (24 hours per day/7 days per week for Nurseline support)	888-364-6352 (TTY 711)	whyuhc.com/shbp
Fraud Hotline: Monday - Friday, 8 a.m. - 8 p.m. ET	888-364-6352	
Wellness Program Administrator		
Sharecare Member Services: Monday - Friday, 8 a.m. - 8 p.m. ET	888-616-6411 (TTY 711)	bewellshbp.com
Corporate Compliance Hotline: 24 hours per day/7 days per week	844-401-0005 (TTY 711)	
Pharmacy Administrator		
CVS Caremark® Member Services: 24 hours per day/7 days per week	844-345-3241	info.caremark.com/shbp
Teletype (TTY) Line	800-231-4403	
Fraud Hotline: 24 hours per day/7 days per week	877-287-2040	
SHBP		
SHBP Member Services Open Enrollment: Monday - Friday, 8:30 a.m. - 7:30 p.m. ET, Regular Business Hours: Monday - Friday, 8:30 a.m. - 5 p.m. ET	800-610-1863	mySHBPga.adp.com
Additional Information		
TRICARE Supplement	866-637-9911	info.selmanco.com/ga_shbp
Social Security Administration	800-772-1213	ssa.gov
Centers for Medicare & Medicaid Services (CMS)		
24 hours a day/7 days per week	800-633-4227 TTY 877-486-2048	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 and retired, to read all Plan materials provided to fully understand the provisions of the option chosen. Availability of SHBP Options may change based on federal or state law changes or as approved by the Board of Community Health. Premiums for SHBP options are established by the Board of Community Health and may be changed at any time by Board Resolution, subject to advance notice.

2023 Open Enrollment for Plan Year 2024

Welcome to the State Health Benefit Plan's (SHBP) Open Enrollment (OE) for the 2024 Plan Year. OE gives you the opportunity to review your Plan Options and make changes to your coverage based on your needs. Please read this document carefully to ensure you are choosing the option that best meets you and your covered dependents' healthcare needs.

CONTENTS

COMMON HEALTH CARE ACRONYMS	
ANTHEM	ANTHEM BLUE CROSS AND BLUE SHIELD
CMS	CENTERS FOR MEDICARE & MEDICAID SERVICES
DCH	DEPARTMENT OF COMMUNITY HEALTH
FSA	FLEXIBLE SPENDING ACCOUNT
HDHP	HIGH DEDUCTIBLE HEALTH PLAN
HIA	HEALTH INCENTIVE ACCOUNT
HMO	HEALTH MAINTENANCE ORGANIZATION
HRA	HEALTH REIMBURSEMENT ARRANGEMENT
HSA	HEALTH SAVINGS ACCOUNT
KP	KAISER PERMANENTE
KPRA	KAISER PERMANENTE ROLLOVER ACCOUNT
MAPD	MEDICARE ADVANTAGE WITH PRESCRIPTION DRUGS
MIA	MYINCENTIVE ACCOUNT
PCP	PRIMARY CARE PHYSICIAN
PPO	PREFERRED PROVIDER ORGANIZATION
QE	QUALIFYING EVENT
RRA	RETIREE REIMBURSEMENT ACCOUNT
ROCP	RETIREE OPTION CHANGE PERIOD
SHBP	STATE HEALTH BENEFIT PLAN
SPC	SPECIALIST
SPD	SUMMARY PLAN DESCRIPTION
UHC	UNITEDHEALTHCARE

GEORGIA DEPARTMENT OF COMMUNITY HEALTH

Brian P. Kemp, Governor Russel Carlson, Commissioner

2 Martin Luther King Jr. Drive SE, East Tower | Atlanta, GA 30334 | 404-656-4507 | www.dch.georgia.gov

Dear State Health Benefit Plan Member,

Welcome to the State Health Benefit Plan (SHBP) 2024 Open Enrollment through the Georgia Department of Community Health. I look forward to assisting you as we further our mission to provide Georgians with access to affordable, quality health care.

For the 2024 Plan Year, I am happy to share that SHBP will again offer a comprehensive benefit package for active and pre-65 retired members.

Active members and pre-65 retired members will have access to the same high-quality plan designs that were offered in Plan Year 2023, which include:

- The Gold, Silver and Bronze Health Reimbursement Arrangement (HRA) Plan Options offered by Anthem Blue Cross and Blue Shield (Anthem),
- The High Deductible Health Plan (HDHP) Option offered by UnitedHealthcare,
- The statewide Health Maintenance Organization (HMO) Plan Options offered by Anthem and UnitedHealthcare, and
- The regional HMO Plan Option offered by Kaiser Permanente.

Additionally, in most plan options, CVS Caremark® will continue to administer pharmacy benefits for members and their covered dependents, and Sharecare will continue to administer the *Be Well SHBP®* well-being program for our active and pre-65 retirees and their covered spouses. I encourage you to take advantage of the wellness incentives administered by Sharecare by visiting the *Be Well SHBP* website: **bewellshbp.com**. For those who choose Kaiser Permanente, there are also wellness incentives available for participating in its wellness program. Please visit **my.kp.org/shbp** for more information.

SHBP offers two ways to make your elections during Open Enrollment beginning Monday, October 16, midnight ET through Friday, November 3, 2023, 11:59 p.m. ET:

1. Online in the SHBP enrollment portal at **mySHBPga.adp.com** or
2. By contacting SHBP member services at **800-610-1863** during its extended hours for Open Enrollment: Monday - Friday from 8:30 a.m. to 7:30 p.m. ET.

I encourage you to take advantage of the flexibility that the SHBP enrollment portal offers during the Open Enrollment period, including 24-hour access, seven days per week, where you can enroll at your convenience.

Before I close, I want to acknowledge the work and service of Anthem, UnitedHealthcare, Kaiser Permanente, CVS Caremark, Sharecare, and our outstanding healthcare professionals who continue to demonstrate their commitment to *Shaping the Future of A Healthy Georgia*. Thank you for all you do.

Sincerely,

Russel Carlson
DCH Commissioner

WELCOME

TO OPEN ENROLLMENT

Greetings,

Let me welcome you to the Georgia Department of Community Health (DCH) State Health Benefit Plan 2024 Open Enrollment (OE) Period. Thank you for the service that you, public school and state employees, provide to so many Georgians.

Starting on Monday, October 16, at midnight, ET through Friday, November 3, 2023, at 11:59 p.m. ET, you will have the opportunity to either continue your current Plan Options or enroll in a different plan that best fits your needs and those of your family.

This 2024 Active Member Decision Guide is a vital resource to assist in your decision-making. It outlines your choices including Plan Option details, comparison charts, and important information that will become effective January 1, 2024 and continue through December 31, 2024.

If you elect not to make any changes during the annual OE, your current coverage will remain in effect. Even if you elect not to make changes, it is a good idea to review your contact and enrollment information to ensure it is correct. Additionally, you may view the 2024 plan documents and other useful information regarding SHBP on our website at shbp.georgia.gov.

On behalf of Governor Brian Kemp, new DCH Commissioner, Russel Carlson, the Board of Community Health and the entire SHBP family, I encourage you to explore and carefully choose the Plan Option that will meet your unique needs in 2024.

I look forward to supporting you as we continue ***Shaping the Future of A Healthy Georgia*** by providing access to quality healthcare benefits for SHBP members.

Sincerely,

Louis A. Amis
Executive Director, SHBP

2024

Medical Claims Administrators and Plan Options

Medical Claims Administrators

Anthem Blue Cross and Blue Shield (Anthem), Kaiser Permanente (KP) and UnitedHealthcare will continue to offer State Health Benefit Plan (SHBP) members the Commercial (active non-MA) Plan Options listed below for 2024.

Plan Options

Health Maintenance Organization (HMO)

- Anthem
- KP (Metro Atlanta Service Area In-Network only)
- UnitedHealthcare

High Deductible Health Plan (HDHP) with an option to open a Health Savings Account (HSA)

- UnitedHealthcare

Health Reimbursement Arrangement (HRA) without co-pays

- Anthem: Gold, Silver and Bronze

WELLNESS INCENTIVES

2024 WELLNESS INCENTIVES AT-A-GLANCE
See 2024 Wellness section for details

Plan Option	Anthem HMO MyIncentive Account (MIA)	Anthem Health Reimbursement Arrangement (HRA)	Kaiser Permanente (KP) Regional HMO	UnitedHealthcare HMO Health Incentive Account (HIA)	UnitedHealthcare HDHP Health Incentive Account (HIA)
	Up to	Up to		Up to	Up to
Member	480	480	$500 Reward Card	480	480
Covered Spouse	480	480	$500 Reward Card	480	480
UnitedHealthcare Reward Card for enrolled member and covered spouse	n/a	n/a	n/a	$250 Reward Card (member) $250 Reward Card (covered spouse)	$250 Reward Card (member) $250 Reward Card (covered spouse)
Potential Total	960	960	$1,000	1,460	1,460

Anthem HRA: *Members enrolled in an Anthem HRA Plan Option will receive SHBP-funded base credits at the beginning of the Plan Year. The amount funded will be based on the member's elected coverage tier. If a member enrolls in an 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. In addition, members and their covered spouses can earn points for participating in the Be Well SHBP® well-being program.*

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

UnitedHealthcare: *Members and their covered spouses enrolled in a UnitedHealthcare Commercial (active non-MA) Plan Option will each receive a $250 UnitedHealthcare Reward Card after satisfying all Be Well SHBP® well-being program requirements and redeeming their points for either well-being incentive credits or a $150 Sharecare Visa Prepaid Card through the Sharecare Redemption Center.*

IMPORTANT PLAN REMINDERS

New Identification Cards

All UnitedHealthcare members, all Anthem members, and new Kaiser Permanente active and pre-65 retiree (non-MA) members will receive new identification cards before January 1st.

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

All members must provide SHBP with their Taxpayer Identification Number (TIN) for themselves and their enrolled dependents upon enrolling in SHBP coverage. The most common type of TIN is a Social Security Number (SSN), but for individuals who are not eligible for an SSN, members may submit an Individual Taxpayer Identification Number (ITIN) or Adoption Taxpayer Identification Number (ATIN). Failure to submit a TIN will result in a loss of coverage and no refund will be issued. For more information, please visit and review the Invalid/No Social Security Number (SSN) FAQs on the SHBP website: **shbp.georgia.gov**.

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

Members should provide their dependent(s) SSN by entering it directly into the SHBP Enrollment Portal at **mySHBPga.adp.com** or by calling SHBP Member Services at 800-610-1863.

Dependent Verification

Certain Qualifying Events (QE) are opportunities for eligible employees employed with SHBP Employing Entities to enroll themselves and/or add eligible dependents to their coverage. SHBP requires documentation to confirm the eligibility of newly added dependents to be covered under the Plan. Please see the Eligibility & Enrollment Provisions at **shbp.georgia.gov** for the acceptable documentation. If you elect to cover dependents, generally, they will be placed in a pending status until: 1) the required documentation confirming eligibility for coverage is submitted within 45 days after you declare the QE and the documentation is approved, or 2) until the deadline to provide the documentation has passed and the QE is automatically canceled; whichever occurs first.

There's Still Time to Earn 2023 Wellness Incentives

Anthem Blue Cross and Blue Shield (Anthem) Commercial (active non-MA) and UnitedHealthcare Commercial (active non-MA) Plan Options: Members and their covered spouses currently enrolled in Anthem and UnitedHealthcare Commercial (active non-MA) Plan Options who have not completed the required health actions or have not taken any actions have until November 30, 2023, to:

- **Complete all required actions;**
- **Submit the 2023 Physician Screening Form to earn the 2023 points; and**
- **All submissions must be received by Sharecare no later than November 30, 2023.**

If you have questions or need help getting started, visit BeWellSHBP.com or contact Sharecare at 888-616-6411.

(CONTINUED)

Kaiser Permanente: Members and their covered spouses currently enrolled in the KP Regional HMO Plan Option have until November 30, 2023 to complete all four wellness activities to receive a $500 reward card. 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.

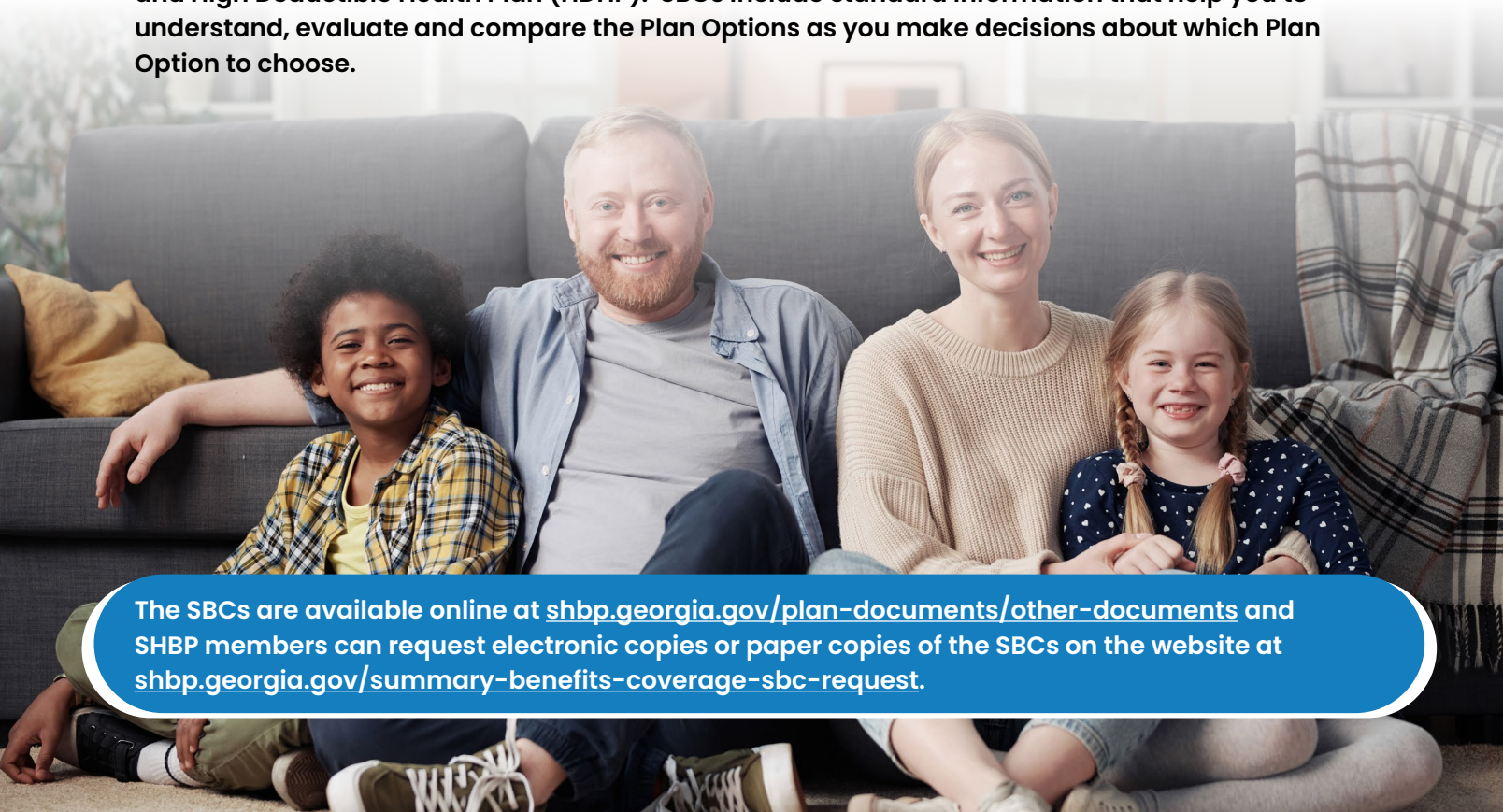
2023 Rollover Credits for Commercial (active non-MA) Plan Options: Regardless of what Plan Option you select, all unused well-being incentive credits earned in 2023 will automatically roll over to the 2024 Plan Option you choose during Open Enrollment. SHBP will deposit your unused credits in the incentive account associated with your 2023 plan selection in April 2024. If you remain with the same Medical Claims Administrator and in the same Plan Option in which you were enrolled in 2023, rollover credits will be available immediately.

Telemedicine/Virtual Visits

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

Summary of Benefits and Coverage (SBC) for Commercial (active non-MA) Plan Options

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



The SBCs are available online at shbp.georgia.gov/plan-documents/other-documents and SHBP members can request electronic copies or paper copies of the SBCs on the website at shbp.georgia.gov/summary-benefits-coverage-sbc-request.

ACTION ALERT

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

ANNUITANT SUBSIDY POLICIES

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

Annuitant Basic Subsidy Policy (Basic Policy)

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

You are subject to the Annuitant Basic Subsidy Policy if:

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

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

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

Annuitant Years of Service Subsidy Policy (YOS Policy)

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

You are subject to the Annuitant YOS Subsidy Policy if on January 1, 2012, you did not have five years of service in the State retirement system from where you will receive an annuity. The subsidy percentage for each member increases with every year of service beginning at 10 years through 30 or more years. Members with 0-9 years of service (i.e., less than 10 years of service) will receive no subsidy.

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

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

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

Years of Service Reporting to SHBP

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

Additional Information

SHBP rate calculators are available online at **shbp.georgia.gov** to assist Retirees with estimating their premiums during the 2023 Plan Year. For questions regarding the YOS Policy, please contact SHBP Member Services at 800-610-1863.

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

OPEN ENROLLMENT (OE) AND YOUR RESPONSIBILITIES

SHBP Enrollment Portal for OE available from October 16, 2023 at midnight through November 3, 2023 at 11:59 p.m. ET

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

- Make your elections online at **mySHBPga.adp.com** no later than November 3, 2023 by 11:59 p.m. ET.
- Make sure you read and understand the plan materials posted at **shbp.georgia.gov** and take the required actions.
- Check your payroll deduction to verify that the correct deduction amount has been submitted. If you are not being charged the correct amount, immediately contact your HR department.
- Update any changes in contact information (i.e., address, email, phone number) by notifying your HR department.
- Notify SHBP whenever you have a change in covered dependents within 31 days of a Qualifying Event (QE) by visiting the SHBP Enrollment Portal at **mySHBPga.adp.com** 24 hours a day/7 days per week or contacting SHBP Member Services at 800-610-1863 for assistance.
- Provide your Medicare Part B information directly to SHBP at least one month prior to your retirement if you and/or your covered dependent, as applicable, are age 65 or older.

Note: Failure to do so will result in you and/or your covered dependent(s) remaining enrolled in a SHBP Commercial (active non-MA) Plan Option and you will pay 100% of the unsubsidized premium, which is substantially higher than the SHBP Medicare Advantage Plan Options.

During OE, you may:

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

IMPORTANT NOTE:

- **The election made during OE will be the coverage you have for the entire 2023 Plan Year unless you have a QE that allows a change to your coverage.**
- **Enrolling or discontinuing coverage from individual coverage offered through the Health Insurance Marketplace (exchange) is NOT a QE.**

MAKING YOUR HEALTH BENEFIT ELECTION FOR 2024

Open Enrollment (OE) begins October 16, 2023, midnight ET and ends November 3, 2023, 11:59 p.m. ET

Before making your selection, we urge you to review the Plan Options described in this guide, discuss them with your family, and choose a Plan Option that is best for you and your covered dependents, if applicable. **Due to expected heavy call volume and online traffic, we strongly encourage all members to: 1) confirm your access to the enrollment portal in advance of the Open Enrollment (OE) election start date, and 2) make your election early.**

Unable to Make Elections Online or Need Technical Assistance?

If you are unable to make your election(s) online or need technical assistance, please call SHBP Member Services at 800-610-1863 prior to the last day of OE. Also, confirm that your email address is correct in the enrollment portal.

How to Reset Your Password

Go to the Enrollment Portal: mySHBPga.adp.com

Step 1: Enter Your User ID
Step 2: Click **Forgot Your Password**
Step 3: Follow the instructions to answer a series of security questions (case sensitivity does apply)
Step 4: Create a new Password
Step 5: Click **Continue**

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

If you answer the security questions wrong or spell the answer incorrectly (case sensitivity does apply), you will have two more tries before you are locked out and must begin the process again.

What if I Do Not Take Any Action?

If SHBP does not receive an election from you through the website, or by contacting SHBP Member Services, you have made a decision to take the default coverage below:

- **Currently Enrolled in a SHBP Commercial (active Non-MA) Plan Option in 2023:** If you are enrolled in a Commercial (active non-MA) Plan Option in 2023, you will remain in your current Plan Option and tier with your current Medical Claims Administrator for the 2024 Plan Year.

- **Currently Enrolled in TRICARE Supplement in 2023:** If you are enrolled in the TRICARE Supplement in 2023, you will remain enrolled in the TRICARE Supplement for the 2024 Plan Year.

NOTE: If you paid a Tobacco Surcharge in 2023, it will continue to apply. If you did not pay a Tobacco Surcharge in 2023, you will not pay one if you take the default coverage. Remember, it is your responsibility to notify SHBP immediately if you and/or your covered dependent(s) no longer qualify for the Tobacco Surcharge. Also, it is your responsibility to contact SHBP if you and/or your covered dependent(s) resumes his/her tobacco use. You must notify SHBP if your answer to the Tobacco Surcharge question changes.

How to Make Your 2024 Health Benefit Election Online

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

Step 1: Log on to the SHBP Enrollment Portal.

- If you are a first-time user, you must first register using the registration code **SHBP-GA** and set up a password before making your 2024 election.
- If you are a returning user but have not accessed the website in 45 days, you must first reset your password before making your 2024 election.

Step 2: Under the Open Enrollment window, click on **Enroll Now** to proceed with your 2024 Plan Year enrollment.

Step 3: If you have not provided a Tobacco Surcharge response in the past, you must first answer the Tobacco Surcharge questions before going to **Review Your Benefits**.

Step 4: Click on **Review Your Info (if applicable).** Verify that each dependent has a valid Social Security Number (SSN) or other Taxpayer Identification Number (TIN).

Step 5: To start your Election Process, click on **Enroll in Benefits** tab.

Step 6: Select **Change**. After you select Change, the Decision Support box will display.

Step 7: Click on **Health Coverage or Dependent Health Coverage** to choose your medical claims administrator(s), your plan option(s), and coverage tier(s).

Step 8: Make Your Elections.

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

If you choose **NOT** to enroll in a Plan Option you must **click** the radio option for **No Coverage**. A pop-up box will then display **Reason for Waive**. You will need to use the drop-down box of populated responses to select a reason for waiving. The **Reason for Waive** must be populated to move to the next step.

Step 9: Click on **Save and Return to All Benefits.** "Your Elections" will display on the screen and show the elections you made. You should carefully review your elections before confirming.

Step 10: Click **I Agree and Confirm Elections.** If I Agree and Confirm Elections is NOT clicked, your enrollment process has not been completed, which means you have decided to make no changes for 2024.

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

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

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

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

OPEN ENROLLMENT (OE) CHECKLIST

- ☑ Verify all desired dependents are listed on the Confirmation Page and have a valid Social Security Number or other Taxpayer Identification Number;
- ☑ 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 active non-MA plan options only);
- ☑ Confirm that you have clicked Finish; and
- ☑ Print the confirmation page and save for your records.

NOTE: You may go online multiple times; however, the last option confirmed at the close of OE will be your option for 2024 unless you experience a Qualifying Event (QE) that allows you to make a change.

Flexible Benefits Program

SHBP does not provide Flexible Benefits (e.g., dental, vision). If you are eligible to make flexible benefit elections through your Employer, please contact your HR Department, or the Flexible Benefits Program administered by the Department of Administrative Services (DOAS) by visiting GABreeze.ga.gov or call 877-342-7339.

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 2023 Open Enrollment (OE) will be the coverage you have for the entire 2024 Plan Year, unless you have a Qualifying Event (QE) that allows a change in your coverage. You only have 31 days after a QE to add a dependent (90 days to add a newly eligible dependent child). For a complete description of QEs, see the Eligibility & Enrollment Provisions document available online at shbp.georgia.gov.

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

QEs include, but are not limited to:

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

Eligible Dependents*

The State Health Benefit Plan (SHBP)covers eligible dependents who meet SHBP guidelines. Eligible dependents include:

- Spouse
- Dependent child(ren), including:
  - Natural child
  - Adopted child
  - Stepchild
  - Child due to Guardianship

Visit the Eligibility and Enrollment Provisions document at shbp.georgia.gov for more information on continuation of coverage for covered dependents disabled prior to age 26.

How to Declare a Qualifying Event

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

Note: You can declare a Qualifying Event (QE) in the SHBP Enrollment Portal on the day of, but no earlier than, the date on which the event actually occurs. For example, if your spouse loses his/her coverage with his/her current employer on November 30, 2023, you cannot declare the QE in the Enrollment Portal until November 30, 2023 (i.e., date of the event). If you do not declare the QE in the Enrollment Portal within 31 days of November 30, 2023 (i.e., date of the event), you will not be able to make your QE in the Enrollment Portal on a later date. When entering the QE in the portal, you must ensure that you enter the correct date of the event as this calculates the effective date of the change resulting from the QE. You may also call SHBP Member Services within the 31 days of the QE and the representatives will make the necessary changes for you.

If you elect to cover dependents, generally, they will be placed in a pending status until: 1) the required documentation confirming eligibility for coverage is submitted within 45 days after you declare the QE and the documentation is approved, or 2) until the deadline to provide the documentation has passed and the QE is automatically canceled, whichever occurs first.

ACTION ALERT

If you are having a baby, you MUST contact SHBP Member Services at 800-610-1863 to add your newborn child and submit the Social Security Number (SSN) or other Taxpayer Identification Number (TIN) within 90 days of the birth in order for the baby to be covered as a dependent by SHBP. You may also have to change Plan Tiers. For additional information, please see SHBP's Eligibility & Enrollment Provisions document available online at shbp.georgia.gov.

New Hires

New Hires Must Make their Election Directly with SHBP within 31 Days of their Hire Date

SHBP requires that new hires make their elections *directly* in the SHBP Enrollment Portal at **mySHBPga.adp.com** or by contacting SHBP Member Services at 800-610-1863 within 31 days of their hire date. Making your election with your employer or through any other process does not satisfy this requirement. If you fail to enroll in SHBP coverage as a new hire, your next opportunity to enroll in SHBP coverage will be during the next Open Enrollment period, unless you have a Qualifying Event that allows a change to your coverage.

For more information on how to make your election, please see the section: Making Your Health Benefit Election for 2024.

Rehires and Transfers

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

Effective Date of Coverage

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

Examples:

- If hired October 15, 2023, one full calendar month following October is November 1, 2023 – November 30, 2023, and coverage would begin the first day of the month following November, which would be December 1, 2023.
- If hired November 1, 2023, since the hire date is concurrent with the first day of the month, coverage would begin the first day of the following month, which would be December 1, 2023.
- If hired January 31, 2024, one full calendar month following January is February 1, 2024 – February 28, 2024, and coverage would begin the first day of the month following February, which would be March 1, 2024.

***Note: If the first day of the month falls on a weekend or holiday, the next business day is considered the first day of the month for SHBP purposes.**

2024 SHBP COMMERCIAL (ACTIVE NON-MA) PLAN OPTIONS

SHBP Members may elect a Commercial (active non-MA) Plan Option, which includes the following:

Anthem Blue Cross and Blue Shield (Anthem)

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

UnitedHealthcare

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

Kaiser Permanente (KP)

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

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

Additional Option

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

CVS Caremark®

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

NOTE: Members do not have to go to a CVS pharmacy location for their prescriptions. CVS Caremark has a broad pharmacy network. Use CVS Caremark's pharmacy locator tool to find a network pharmacy near you. info.caremark.com/shbp

Sharecare/*Be Well SHBP*®

Provides comprehensive well-being resources and incentive programs for members who enroll in Anthem and UnitedHealthcare Commercial (active non-MA) Plan Options. Sharecare will also administer the 2024 action based health incentives that will allow these SHBP members and their covered spouses to earn additional points.

Understanding Your Plan Options For 2024

How the Health Reimbursement Arrangement (HRA) with Anthem Blue Cross and Blue Shield (Anthem) Works

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

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

SHBP contributes HRA credits to your HRA account based on the HRA Plan Option and tier in which you are enrolled. If you have unused credits in your HRA account from 2023, those credits will roll over to the next Plan Year as long as you remain enrolled in an SHBP Plan Option, excluding TRICARE Supplement. If you were previously a member of another SHBP Plan Option, all unused 2023 well-being incentive credits will roll over to your 2024 HRA plan, or any other Plan Option, in April 2024.

NOTE: There is a date limitation to how the 2023 rollover credits can be used for reimbursement. Only eligible medical and pharmacy expenses incurred after the rollover in April 2024 will qualify for reimbursement using the 2023 rollover credits. Eligible medical and pharmacy expenses incurred between January and March 2024 are not eligible for reimbursement using 2023 rollover credits, unless you elect to remain in an HRA. If you stay in an HRA, rollover credits will be available by the end of January 2024. However, until your unused 2023 credits roll over, your 2024 HRA credits funded by SHBP and any well-being incentive credits earned in 2024 (and available at the time claims are received), will be used to offset those eligible medical and pharmacy expenses incurred during this time period.

PLAN FEATURES

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

Understanding Your Plan Options For 2024

How the High Deductible Health Plan (HDHP) with UnitedHealthcare Works

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

For members and their covered spouses enrolled in a UnitedHealthcare Plan Option, please see the 2023 Wellness section for more information about the additional $250 Reward Card offered through UnitedHealthcare. Credits earned by participating in the *Be Well SHBP®* well-being program are added to your HIA once the points have been redeemed through the Sharecare Redemption Center. Any remaining credits will rollover to the next plan year.

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

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

PLAN FEATURES

- There are separate in-network and out-of-network deductibles and out-of-pocket maximums.
- You pay co-insurance after meeting the deductible for all eligible medical and pharmacy expenses until the out-of-pocket maximum is met.
- You do not have to obtain a referral to see a Specialist (SPC); however, we encourage you to select a PCP to help coordinate your care.
- There are no co-pays.
- The medical and pharmacy out-of-pocket maximums are combined.
- Before you can use well-being incentive credits, members must meet the deductible threshold ($1,600 individual; $3,200 other tiers).
- Certain drug costs are waived if SHBP is primary and you actively participate in one of the Disease Management (DM) Programs for diabetes, asthma, coronary artery disease, and/or medications for addiction treatment. Members must satisfy the deductible threshold ($1,600 individual; $3,200 other tiers).
- The Plan pays 100% of covered services provided by in-network providers that are properly coded as "preventive care" within the meaning of the Affordable Care Act (ACA).
- Select generics, listed on the Generic Maintenance Drug List, can be obtained for a co-insurance without having to meet the deductible first.
- Telemedicine/virtual visits for certain medical services are available.

How the High Deductible Health Plan (HDHP) with UnitedHealthcare Works (continued)

Health Savings Account (HSA)

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

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

You can open an HSA if you enroll in the State Health Benefit Plan (SHBP) High Deductible Health Plan (HDHP) and do not have other coverage through:

1) Your spouse's employer's plan,
2) Medicare, or
3) Medicaid

HSA Features:

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

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

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

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

For members and their covered spouses enrolled in a UnitedHealthcare Plan Option, please see the 2024 Wellness section for more information about the additional $250 Reward Card offered through UnitedHealthcare. Credits earned by participating in the *Be Well SHBP®* well-being program are added to your HIA or MIA once the points have been redeemed through the Sharecare Redemption Center; any remaining credits will roll over to the next plan year.

PLAN FEATURES

- There are co-pays with this plan for certain services.
- Certain services are subject to a deductible and co-insurance (see the Benefits Comparison Chart).
- You do not have to obtain a referral to see a Specialist (SPC); however, we encourage you to select a PCP to help coordinate your care.
- Coverage is only available when using in-network providers (except for emergency care).
- The Plan pays 100% of covered services provided by in-network providers that are properly coded as "preventive care" within the meaning of the Affordable Care Act (ACA).
- Co-pays count toward your out-of-pocket maximum.
- Co-pays do not count toward your deductible.
- The medical and pharmacy out-of-pocket maximums are combined.
- Certain drug costs are waived if SHBP is primary and you actively participate in one of the Disease Management Programs (DM) for diabetes, asthma, coronary artery disease, and/or medications for addiction treatment.
- Telemedicine/virtual visits are available.

HOW THE REGIONAL HEALTH MAINTENANCE ORGANIZATION WITH KAISER PERMANENTE WORKS

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

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

Choose your own Primary Care Physician (PCP) from a network of carefully selected Kaiser Permanente providers in 25 medical facilities. You won't need a referral for dermatology, behavioral health, OB/GYN, optometry or ophthalmology. For other specialties, your PCP can coordinate any specialty care you might need. To select a PCP, you can log on to my.kp.org/shbp or call KP's Member Services at 855-512-5997.

The KP Regional 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.

PLAN FEATURES

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

Benefits Comparison Summary:

SHBP Commercial (active non-MA) Plan Options

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

Benefits Comparison Summary:

HRA Plans | January 1, 2024 - December 31, 2024

	Anthem Gold HRA Option		Anthem Silver HRA Option		Anthem 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 Credits	The Plan Pays		The Plan Pays		The Plan Pays	
• You • You + Spouse • You + Child(ren) • You + Family	$400 $600 $600 $800		$200 $300 $300 $400		$100 $150 $150 $200	
Physicians' Services	The Plan Pays		The Plan Pays		The Plan Pays	
Primary Care Physician or Specialist Office or Clinic Visits • Treatment of illness or injury	85% coverage; subject to deductible	60% coverage; subject to deductible	80% coverage; subject to deductible	60% coverage; subject to deductible	75% coverage; subject to deductible	60% coverage; subject to deductible
Maternity Care (non-routine, prenatal, delivery, and postpartum)	85% coverage; subject to deductible	60% coverage; subject to deductible	80% coverage; subject to deductible	60% coverage; subject to deductible	75% coverage; subject to deductible	60% coverage; subject to deductible
Primary Care Physician or Specialist Office or Clinic Visits for the following: • Wellness care/ preventive health care • Prenatal care coded as preventive	100% coverage; not subject to deductible	Not covered	100% coverage; not subject to deductible	Not covered	100% coverage; not subject to deductible	Not covered
Physician Services Furnished in a Hospital • Inpatient Visits, including charges by surgeon, anesthesiologist, pathologist and radiologist	85% coverage; subject to deductible	60% coverage; subject to deductible	80% coverage; subject to deductible	60% coverage; subject to deductible	75% coverage; subject to deductible	60% coverage; subject to deductible
Telemedicine/Virtual visit	85% coverage; not subject to deductible	Not covered	80% coverage; not subject to deductible	Not covered	75% coverage; not subject to deductible	Not covered

Benefits Comparison Summary:

HMO and HDHP Plans | January 1, 2024 - December 31, 2024

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

Benefits Comparison Summary:

HRA Plans | January 1, 2024 - December 31, 2024

	Anthem Gold HRA Option		Anthem Silver HRA Option		Anthem 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 with an outpatient surgery at a facility; including charges by surgeon, anesthesiologist, pathologist and radiologist	85% coverage; subject to deductible	60% coverage; subject to deductible	80% coverage; subject to deductible	60% coverage; subject to deductible	75% coverage; subject to deductible	60% coverage; subject to deductible
Hospital Services	**The Plan Pays**		**The Plan Pays**		**The Plan Pays**	
Inpatient Services • Inpatient care, delivery and inpatient short-term acute rehabilitation services	85% coverage; subject to deductible	60% coverage; subject to deductible	80% coverage; subject to deductible	60% coverage; subject to deductible	75% coverage; subject to deductible	60% coverage; subject to deductible
Inpatient Services • Well newborn care	85% coverage; subject to deductible	60% coverage; subject to deductible	80% coverage; subject to deductible	60% coverage; subject to deductible	75% coverage; subject to deductible	60% coverage; subject to deductible
Outpatient Surgery/Services • At a hospital or other facility	85% coverage; subject to deductible	60% coverage; subject to deductible	80% coverage; subject to deductible	60% coverage; subject to deductible	75% coverage; subject to deductible	60% coverage; subject to deductible
Hospital Emergency Room Care • Treatment of an emergency medical condition or injury	85% coverage; subject to in-network deductible		80% coverage; subject to in-network deductible		75% coverage; subject to in-network deductible	
Outpatient Testing, Lab, etc.	**The Plan Pays**		**The Plan Pays**		**The Plan Pays**	
Non-Routine Laboratory; X-Rays; Diagnostic Tests; Injections • Including medications covered under medical benefits for the treatment of an illness or injury **NOTE:** In-network diagnostic colonoscopies and mammograms are covered at 100%.	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 Summary:

HMO and HDHP Plans | January 1, 2024 - December 31, 2024

	Anthem / UnitedHealthcare Statewide HMO Option	UnitedHealthcare HDHP Option		KP Regional HMO Option
	In-Network Only	In-Network	Out-of-Network	In-Network Only
Physicians' Services	**The Plan Pays**	**The Plan Pays**		**The Plan Pays**
Physician Services for Emergency Care	100% coverage	70% coverage; subject to in-network deductible		100% coverage
Allergy Shots and Serum • Co-pay only applies when billed with an office visit	100% after $35 PCP co-pay $45 SPC co-pay	70% coverage; subject to deductible	50% coverage; subject to deductible	100% after $35 PCP co-pay $45 SPC co-pay
Outpatient Surgery/Services • When billed as an office visit	100% after $35 PCP co-pay $45 SPC co-pay	70% coverage; subject to deductible	50% coverage; subject to deductible	100% after $35 PCP co-pay $45 SPC co-pay
Outpatient Surgery/Services • When billed with an outpatient surgery at a facility, including charges by surgeon, anesthesiologist, pathologist and radiologist	80% coverage; subject to deductible	70% coverage; subject to deductible	50% coverage; subject to deductible	100% coverage after $100 co-pay
Hospital Services	**The Plan Pays**	**The Plan Pays**		**The Plan Pays**
Inpatient Services • Inpatient care, delivery and inpatient short-term acute rehabilitation services	80% coverage; subject to deductible	70% coverage; subject to deductible	50% coverage; subject to deductible	100% coverage after $250 co-pay
Inpatient Services • Well newborn care	100% coverage	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 $200 co-pay, if admitted co-pay waived	70% coverage; subject to in-network deductible		100% coverage after $200 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 **NOTE:** In-network diagnostic colonoscopies and mammograms are covered at 100%. ***For HDHP, deductible threshold must be met first.**	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 freestanding imaging center $100 co-pay at outpatient hospital facility

Benefits Comparison Summary:

HRA Plans | January 1, 2024 – December 31, 2024

	Anthem Gold HRA Option		Anthem Silver HRA Option		Anthem 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 Use Disorder (MH/SUD) Inpatient Facility and Residential Treatment Centers **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
MH/SUD: Group Outpatient Visits, Intensive Outpatient, Partial Day Hospitalization, and Methadone Clinics	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
MH/SUD: Outpatient Visits Professional and Methadone Clinics	85% coverage; subject to deductible	60% coverage; subject to deductible	80% coverage; subject to deductible	60% coverage; subject to deductible	75% coverage; subject to deductible	60% coverage; subject to deductible
Other Coverage	**The Plan Pays**		**The Plan Pays**		**The Plan Pays**	
Outpatient Acute Short-Term Rehab Services • Physical, Speech and Occupational Therapies • Other Short-Term Rehab Services **NOTE:** There is a benefit maximum of 40 visits (combined in-network and out-of-network) per therapy in a benefit year.	85% coverage; subject to deductible	60% coverage; subject to deductible	80% coverage; subject to deductible	60% coverage; subject to deductible	75% coverage; subject to deductible	60% coverage; subject to deductible
Chiropractic Care Coverage up to a maximum of 20 visits per Plan Year	85% coverage; subject to deductible	60% coverage; subject to deductible	80% coverage; subject to deductible	60% coverage; subject to deductible	75% coverage; subject to deductible	60% coverage; subject to deductible
Vision Routine Eye Exam **NOTE:** • Limited to one eye exam every 24 months. • Dilated retinal eye exam is covered at 100% once per calendar year	100% coverage; not subject to deductible Out-of-network eye exam not covered		100% coverage; not subject to deductible Out-of-network eye exam not covered		100% coverage; not subject to deductible Out-of-network eye exam not covered	
Hearing Services Routine Hearing Exam when properly coded as preventive	100% coverage	Not covered	100% coverage	Not covered	100% coverage	Not covered
Hearing Services Non-routine hearing not performed in an office setting	85% coverage; subject to deductible	60% coverage; subject to deductible	80% coverage; subject to deductible	60% coverage; subject to deductible	75% coverage; subject to deductible	60% coverage; subject to deductible
Hearing Aid: Adult 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 per hearing impaired ear every four years; not subject to deductible		80% coverage for exam and fittings; subject to deductible $3,000 hearing aid allowance per hearing impaired ear every four years; not subject to deductible		75% coverage for exam and fittings; subject to deductible $3,000 hearing aid allowance per hearing impaired ear every four years; not subject to deductible	

Benefits Comparison Summary:

HMO and HDHP Plans | January 1, 2024 – December 31, 2024

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

Benefits Comparison Summary:

HRA Plans | January 1, 2024 - December 31, 2024

	Anthem Gold HRA Option		Anthem Silver HRA Option		Anthem 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.	85% coverage not subject to deductible		80% coverage not subject to deductible		75% coverage not subject to deductible	
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 Claim Administrator for coverage details					

Benefits Comparison Summary:

HMO and HDHP Plans | January 1, 2024 - December 31, 2024

	Anthem/ 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.	100% after $35 PCP co-pay $45 SPC co-pay	70% coverage; subject to deductible		100% after $35 PCP co-pay $45 SPC co-pay
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 up to 120 days per Plan Year
Hospice Care **NOTE:** Prior approval required.	100% coverage	70% coverage; subject to deductible	50% coverage; subject to deductible	100% coverage
Durable Medical Equipment (DME) - Rental or purchase **NOTE:** Prior approval required for certain DME.	100% coverage	70% coverage; subject to deductible	50% coverage; subject to deductible	100% coverage
Transplant Services **NOTE:** Prior approval required.	Contact the Medical Claim Administrator for coverage details			

Benefits Comparison Summary:

HRA Plans | January 1, 2024 - December 31, 2024

	Anthem Gold HRA Option		Anthem Silver HRA Option		Anthem Bronze HRA Option	
	In-Network	Out-of-Network*	In-Network	Out-of-Network*	In-Network	Out-of-Network*
Other Coverage	**You Pay**		**You Pay**		**You Pay**	
Tier 1 **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 **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 **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 **NOTE:** Per 90-day maximum supply.	Tier 1–15% ($50 min/$125 max) Tier 2–25% ($125 min/$200 max) Tier 3–25% ($200 min/$312.50 max)		Tier 1–15% ($50 min/$125 max) Tier 2–25% ($125 min/$200 max) Tier 3–25% ($200 min/$312.50 max)		Tier 1–15% ($50 min/$125 max) Tier 2–25% ($125 min/$200 max) Tier 3–25% ($200 min/$312.50 max)	

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

Additional information

- *Amounts you pay go toward the out-of-pocket maximum.*
- *If you or your physician request a Brand-name Prescription Drug Product in place of the chemically equivalent Prescription Drug Product (Generic equivalent), you will pay the applicable Brand co-insurance in addition to the difference between the Brand and Generic Drug costs. This differential will apply toward your out-of-pocket maximum.*
- *CVS Caremark® administers the pharmacy benefits for members enrolled in Anthem HRA Plan Options.*
- *While the pharmacy co-pay/co-insurance amounts are not changing for 2024, you may want to check to see if the medications you are taking have changed tiers for 2024.*

Benefits Comparison Summary:

HMO and HDHP Plans | January 1, 2024 - December 31, 2024

	Anthem/UnitedHealthcare Statewide HMO Option	UnitedHealthcare HDHP Option		KP Regional HMO Option
	In-Network Only	In-Network	Out-of-Network*	In-Network Only
Other Coverage	**You Pay**	**The Plan Pays**		**You Pay**
Tier 1 **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 **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 **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 **NOTE:** Per 90-day maximum supply.	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:** For HDHP Out-of-Network, please refer to the High Deductible Health Plan (HDHP) plan option Summary Plan Description (SPD).*

Additional information

- *Co-pay amounts you pay do not go toward the deductible for Anthem or UHC HMO, but do for the UHC HDHP. Co-pay amounts paid do go toward the out-of-pocket maximum for the Anthem and the UHC HMO and the HDHP.*
- *The HDHP Plan now includes a Generic Maintenance Drug List. If you take medications on the Generic Maintenance Drug List, you do not have to meet the deductible before your co-insurance rate is applied. You will pay the 30% co-insurance beginning on your first fill of these select medications on the approved list. If you have questions about the Generic Maintenance Drug List, call Customer Care at*
- *1-844-345-3241 or go to **info.caremark.com/shbp**.*
- *For the Anthem and UHC plans, if you or your physician request a Brand-name Prescription Drug Product in place of the chemically equivalent Prescription Drug Product (Generic equivalent), you will pay the applicable Brand co-pay/co-insurance in addition to the difference between the Brand and Generic Drug costs. This differential will apply towards your out-of-pocket maximum.*
- *CVS Caremark® administers the pharmacy benefits for members enrolled in Anthem HMO and UnitedHealthcare HMO and HDHP Plan Options. Kaiser Permanente administers the pharmacy benefits for members enrolled in their Plan Option.*
- *While the pharmacy co-pay/co-insurance amounts are not changing for 2024, you may want to check to see if the medications you are taking have changed tiers for 2024.*

ALTERNATIVE COVERAGE

TRICARE Supplement for Eligible Military Members

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

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

Who is eligible for enrollment in the TRICARE Supplement Plan?

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

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

Points to consider if you elect TRICARE Supplement Plan coverage

- Effective January 1, 2024, TRICARE will become your primary coverage
- TRICARE Supplement Plan will become the secondary coverage
- The eligibility rules and benefits described in the TRICARE Supplement Plan will apply:
  - Unmarried adult children under the age of 26 who are no longer eligible for regular TRICARE must be enrolled in TRICARE Young Adult (TYA) through TRICARE before enrolling in the TRICARE Supplement Plan
  - Unmarried children under the age of 21 or 23 if a full-time student who are no longer eligible for regular TRICARE, must be enrolled in TYA through TRICARE before enrolling in the TRICARE Supplement Plan
- Tobacco Surcharge will not apply

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

2024 WELLNESS

Wellness for Members Enrolled in Anthem Blue Cross and Blue Shield (Anthem) and UnitedHealthcare Commercial (Active Non-MA) Plan Options

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

The Sharecare team will provide you with the support, tools and lifestyle management information you need to improve your health and well-being. The types of support you receive include the Sharecare RealAge® Test that determines your body's true age, a highly personalized profile, personalized content to help improve your health habits; access to a personal well-being coach; a biometric screening, healthy living webinars, monthly rotating challenges that encourage daily tracking of healthy behaviors, and access to a library of health and wellness content. As a value-added benefit, *Be Well SHBP* members have access to guided programs designed to foster and encourage relaxation, manage stress and anxiety, promote tobacco cessation, and encourage healthy eating habits. These programs are designed to evolve to meet the needs of participants and include:

- Unwinding: Relax and meditate
- Unwinding Anxiety: Manage stress and anxiety
- Craving to Quit: Quit tobacco and vaping
- Eat Right Now: Manage and control food cravings

To learn more about the many features of the current program, visit **BeWellSHBP.com** or call 888-616-6411.

2024 Well-Being Incentives for Anthem and UnitedHealthcare Commercial (Active Non-MA) Plan Options*

Members and their covered spouses can each earn 480 points and choose to redeem them in the Sharecare Redemption Center for either: 1) a $150 Sharecare Rewards Visa® Prepaid Card (when redeeming all 480 points earned in 2024) OR 2) 480 well-being incentive credits (to apply toward eligible medical and pharmacy expenses)**

If You Complete...	You Will Earn...
The RealAge Test Take a confidential, online questionnaire that will take about 10 minutes to complete. It is recommended that you complete the RealAge Test early in 2024 to allow for completion of action items below.	**120 points******
A Biometric Screening You have three options to complete your Biometric Screening: through your physician, or at an SHBP-sponsored screening event, or at a Quest Diagnostics Patient Service Center (PSC).	**120 points******
Preventive Screening Exams • Complete a preventive screening exam (colonoscopy, mammogram, pap smear or prostate screening).	**Preventive Screening Exams** Earn 60 points for each completed screening exam, up to two times. • Screenings should be completed by August 31, 2024. • For screenings completed in September, October, November, and December 1 & 2, members can self-attest by December 2, 2024.
Well-being Coaching, Online Challenges, Mini-programs, or a Combination of all Three	**Up to 240 points in the following increments********
Well-being Coaching Actively engage with a Sharecare well-being coach.	**Well-being Coaching** • Earn 40 points for each completed coaching call per calendar month, up to 6 times. • Maximum of one call in a calendar month qualifies you for the 40 points. • Maximum of 240 points.
Online Challenges & Mini-programs Within the Sharecare app or on the online platform, join and complete a monthly challenge or watch the videos in a mini-program. These activities cover four different wellness areas: physical health, diet & nutrition, stress management, and sleep.	**Online Challenges & Mini-programs** Earn 40 points up to 6 times, for a maximum of 240 points by completing the following challenges and/or mini-programs in the month they're offered. • Physical: January, April, June • Diet & Nutrition: February, July, October • Stress Management: May, September, November • Sleep: March, August

***All actions must be completed and appropriate documentation submitted and received by Sharecare between January 1, 2024 and December 2, 2024. This includes the Biometric Screening through your physician by completing the 2024 Physician Screening Form, or at an SHBP-sponsored screening event, or at a Quest Diagnostics Patient Service Center (PSC). It is your responsibility to ensure your information is complete and all documentation is received by Sharecare by December 2, 2024.**

****Points are saved in the Sharecare Redemption Center until you choose to redeem them, meaning points will not be sent automatically to Anthem or UnitedHealthcare. Therefore, members must make their selection on how they choose to redeem their points through the Sharecare Redemption Center, by visiting BeWellSHBP.com.**

*****If you elect to redeem your points for well-being incentive credits to apply toward eligible medical and pharmacy expenses, you may do so in increments of 120 (up to a maximum of 480). Credits will be available within 30 days of redemption and will be deposited into your HRA, MIA or HIA account. You will not be able to select the Visa Prepaid Card option if you begin redeeming points for incentive credits. If you elect to redeem all 480 points earned in 2024 for the Visa Prepaid Card, it can be used anywhere Visa is accepted and will be physically mailed within 8 weeks of redemption. The Visa Prepaid Card will expire 12 months after the issuance date.**

******Note: Points cannot be awarded until completion of the RealAge Test. Biometrics, Well-being Coaching, Online Challenges, Mini-programs and Preventive Screening Exams can only be applied to points upon RealAge Test completion.**

Important Reminder: Remember to redeem points before transferring into a Medicare Advantage Plan as points are not automatically redeemed and transferred for Medicare Advantage members.

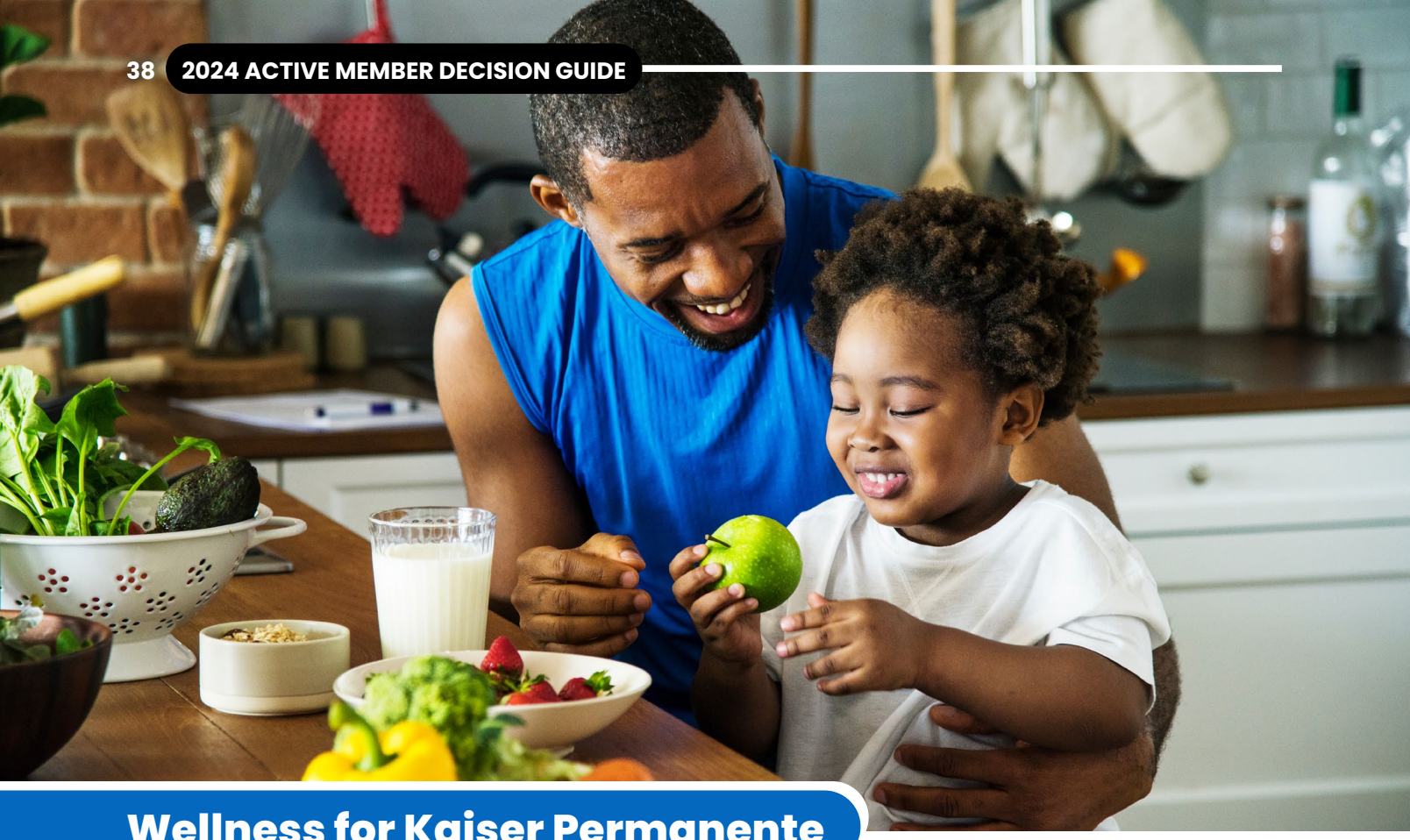
To learn more about how well-being incentives work with your Plan Option, please see the chart on the next page: "How Your Well-being Incentive Credits Work with Your Plan Option"

How Your Well-Being Incentive Credits Work with Your Plan Option

After you choose to redeem your points in the Sharecare Redemption Center for well-being incentive credits to apply toward eligible medical and pharmacy expenses (which you may do so in increments of 120, up to a maximum of 480), credits will be available within 30 days of redemption. Credits will be deposited into your MIA, HRA or HIA account. ***See 2024 Well-Being Incentives for Anthem and UnitedHealthcare Commercial (active non-MA) Plan Options chart for details below.***

Plan Option	Account Type	When You Must Redeem Your Points for Credits	How Your Credits Work
Anthem HMO	MyIncentive Account (MIA)	All points earned in 2024 must be redeemed through Sharecare's Redemption Center (points will not be sent automatically to your Medical Claims Administrator).	When you use your benefits, you pay the member responsibility, including provider/ pharmacy co-pay, co-insurance or deductible as you normally would. Once the claim has been paid, information is sent to the MIA program. If you have MIA credits to cover all, or a portion of the member responsibility that you've paid, Anthem will reimburse you (up to the amount of MIA credits available) by mailed check or you can set-up direct deposit along with a MIA Summary.
Anthem HRA	Health Reimbursement Account (HRA)	Members enrolled in an HRA plan option receive account-based credits funded by SHBP, which are available immediately and do not require redemption in the Sharecare Redemption Center. All points earned in 2024 must be redeemed through Sharecare's Redemption Center (points will not be sent automatically to your Medical Claims Administrator).	When you use your benefits, any funds that are owed to providers/pharmacies will be automatically paid by Anthem out of your HRA first. You will not pay anything until all of your available HRA credits have been used.
UnitedHealthcare HMO	Health Incentive Account (HIA)	Members and their covered spouses enrolled in a UnitedHealthcare HMO Plan Option are each eligible to receive a $250 UnitedHealthcare Reward Card after satisfying all Be Well SHBP® well-being program requirements and redeeming their points for either well-being incentive credits or $150 Sharecare Visa Reward Card through the Sharecare Redemption Center. All points earned in 2024 must be redeemed through Sharecare's Redemption Center (points will not be sent automatically to your Medical Claims Administrator).	When you use your benefits, you pay the member responsibility, including provider/ pharmacy co-pay, co-insurance or deductible as you normally would. Once the claim has been paid, information is sent to the HIA program. If you have HIA credits to cover all, or a portion of the member responsibility that you've paid, UnitedHealthcare will mail you a reimbursement check (up to the amount of HIA credits available) along with an HIA summary.
UnitedHealthcare HDHP	Health Incentive Account (HIA)	**Members and their covered spouses enrolled in a UnitedHealthcare HDHP Plan Option are each eligible to receive a $250 UnitedHealthcare Reward Card after satisfying all Be Well SHBP® well-being program requirements and redeeming their points for either well-being incentive credits or $150 Sharecare Visa Reward Card through the Sharecare Redemption Center.** **All points earned in 2024 must be redeemed through Sharecare's Redemption Center (points will not be sent automatically to your Medical Claims Administrator).**	**You first pay a portion* of your deductible to activate your ability to use your HIA credits. Once that portion of your deductible has been met, when you use your benefits, any funds owed to providers will be automatically paid by UnitedHealthcare out of your HIA (up to the amount of HIA credits available).** **For pharmacy, you will pay upfront. If you have enough credits in your HIA to cover all, or a portion of the expense, UnitedHealthcare will automatically mail you a reimbursement check (up to the amount of HIA credits available).** ***Portion of Your Deductible:** **You: $1,500** **You + Child(ren): $3,000** **You + Spouse: $3,000** **You + Family: $3,000** **The above amounts reflect a portion of the total required Deductible.**

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



Wellness for Kaiser Permanente

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

Kaiser Permanente Rollover Account (KPRA)

The KPRA will be available to members enrolling with KP who were previously enrolled in another SHBP Plan Option during 2023 that have unused incentive credits earned in SHBP's *Be Well SHBP®* program administered by Sharecare. The balance will roll over in April 2024. With the KPRA, members will be able to use those unused credits for eligible medical and pharmacy expenses incurred after April 2024, while insured under the KP Regional HMO plan. If you have questions regarding your KPRA, contact KPRA customer service after April 2024 at 877-761-3399 or visit **kp.org/healthpayment**.

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

2024 Wellness Incentives for Kaiser Permanente

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

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

Getting your reward is easy. To get started, visit kp.org/engage to sign on and accept your wellness program agreement (required for reward eligibility). From there you can check the status of your activities which do not have to be completed in any specific order. For details or questions, visit my.kp.org/shbp or call 866-300-9867.

NOTE: All actions must be completed between January 1, 2024 and November 30, 2024.

	What to Do	What You Will Earn
1.	**Accept your Wellness Program Agreement:** Sign on to kp.org/engage to accept your Wellness Program Agreement - check "yes," then click submit. If you check "no" or if you don't complete this step, you will not earn credit for your Kaiser Permanente Wellness Program activities.	***How will YOU use your $500 wellness incentive reward? Complete all five activities and earn a reward card worth $500 to spend on anything you choose!*** • Pay for co-pays and prescription medications for the entire year • Relieve stress with quarterly massages • Take a nice weekend hiking trip in the mountains • Splurge on new work-out clothes or walking shoes • Stock up on healthy foods at the grocery store ***Both members and their covered spouses are eligible to earn the incentive for a total of $1,000 per household.***
2.	**Take Your Total Health Assessment:** Complete your KP Total Health Assessment (THA) online. The questionnaire is confidential and takes about 10 minutes.	
3.	**Know Your Numbers:** Complete a Biometric Screening at a Kaiser Permanente Medical Office, or by a KP clinician at an SHBP-sponsored biometric screening event. **NOTE:** ONLY those screenings performed by KP are eligible for the reward.	
4.	**Get Yourself Screened:** Complete all age and gender appropriate preventive screenings for breast, cervical or colorectal cancer.	
5.	**Make A Lifestyle Change:** Your choice—participate in either Wellness Coaching by Phone or a mission through the healthy lifestyle programs.	

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

TOBACCO POLICIES

Tobacco Cessation

Every attempt to quit tobacco is worth the effort. It takes planning, support and sometimes, all the will power you've got. But quitting for good is absolutely possible. Both Sharecare and Kaiser Permanente offer comprehensive online and telephonic tobacco cessation services that provide the tools and support you need to quit successfully. Both programs are confidential, voluntary and are at no additional cost to you. To learn more, members enrolled in Anthem and UnitedHealthcare should visit **BeWellSHBP.com** and members enrolled in KP should visit **my.kp.org/shbp**.

Tobacco Cessation Medications

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

Tobacco Surcharge

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

Tobacco Surcharge Removal/Refund

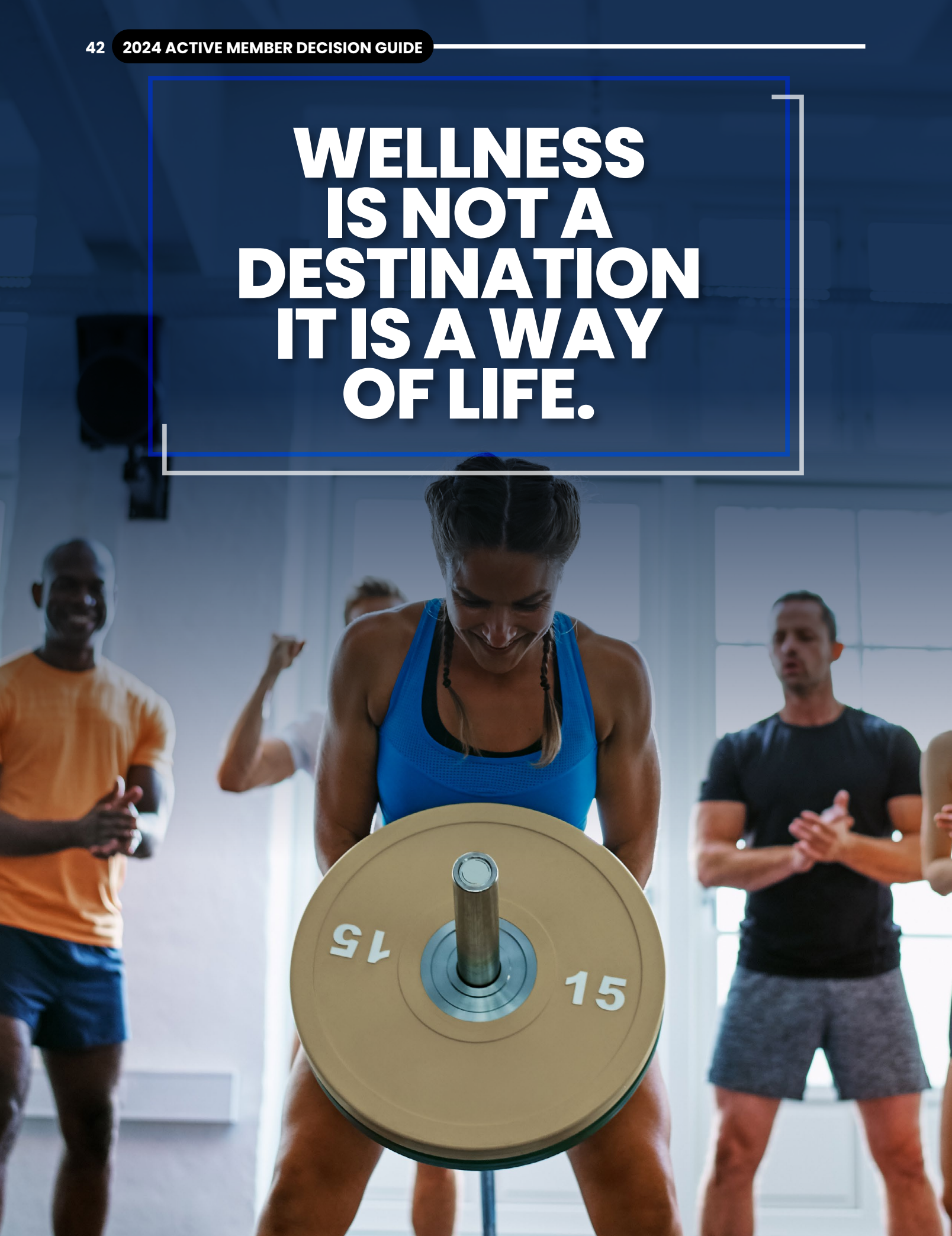
In compliance with the Affordable Care Act (ACA) requirements for wellness programs, SHBP's covered tobacco users (members and covered dependents) may qualify for tobacco surcharge refunds or adjustments of premiums paid in 2024 by completing the Tobacco Surcharge Removal Requirements in the Tobacco Users Cessation Policies for Anthem, UnitedHealthcare and KP at: **shbp.georgia.gov**.

IF YOU ARE RETIRING

Planning to Retire Soon? Here's What You Need to Know

- Before you transition to retirement, review the SHBP Retirement Coverage Presentation on our website at **shbp.georgia.gov**.
- In order to continue your State Health Benefit Plan (SHBP) coverage as a retiree, you and any dependents you want covered must be enrolled in the Plan while you are an active member immediately prior to your retirement. If you are not enrolled in the SHBP and wish to carry coverage as a retiree, you will need to enroll during Open Enrollment the year prior to your retirement. This also applies to any dependent(s) you would like to cover as a retiree, which means you will need to enroll your dependent(s) during Open Enrollment the year prior to your retirement while you are still an active member if you would like them to be covered when you retire.
- If you make a change during Open Enrollment but retire before the change can become effective on January 1, your elections prior to Open Enrollment, including your Plan Option, Tier and covered dependents, will remain the same.
- If you are retiring and under age 65, and 1) fall under the Annuitant Basic Subsidy Policy, your Plan Options and rates are the same as for active members and the Tobacco Surcharge question will apply or 2) fall under the Annuitant Years of Service Subsidy Policy, your Plan Options are the same as for active members but your rates are based on your Years of Service in a State retirement system (e.g. TRS or ERS) and the Tobacco Surcharge question will apply.
- If you are retiring and you or your covered dependents are age 65 or older (or will be turning age 65 at your retirement), you have the option of: 1) enrolling in an active SHBP Medicare Advantage with Prescription Drugs (MAPD) Plan Option if you submit your Medicare Part B enrollment information directly to SHBP, or 2) remaining in a Commercial (active Non-MA) Plan Option, and you will pay 100% of the unsubsidized premium, which is substantially higher than the SHBP Medicare Advantage Plan Options. Medicare Advantage Plan Options are the only Plan Options subsidized by SHBP for Retirees age 65 and older.
- When you retire, check your annuity deductions to verify that the correct deduction amount has been submitted to SHBP. If SHBP determines that you have not submitted your premium payment or your premium payment was a partial payment, or your premium exceeds the maximum amount SHBP will deduct from your annuity, SHBP will bill you directly and you should submit payment according to your invoice. If you are not being charged the correct amount, immediately contact SHBP Member Services at 800-610-1863.
- Once retired, you will have a Retiree Option Change Period (ROCP) that will allow you to only change your Plan Option.
- You may add dependents only if you have a qualifying event (QE) because Retirees do not have an Open Enrollment period.

Please refer to the Retiree Decision Guide for additional information regarding your SHBP coverage and Plan Options as a Retiree


WELLNESS
IS NOT A
DESTINATION
IT IS A WAY
OF LIFE.
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About the Following Notices

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

Penalties for Misrepresentation

If an SHBP participant misrepresents eligibility information when applying for coverage during change of coverage or when enrolling in benefits, the SHBP may take adverse action against the participants, including, but not limited to terminating coverage (for the participant and his or her dependents) or imposing liability to the SHBP for fraud indemnify (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 PCP's, call the telephone number on the back of your Identification Card.

Access to Obstetrical and Gynecological (OB/GYN) Care

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

HIPAA Special Enrollment Notice

If you decline enrollment for yourself or your Dependents (including your spouse) because of other health insurance or group health plan coverage, you may be 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). 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 thirty-one (31) days after the marriage or adoption, or placement for adoption (or within 90 days for a newly eligible dependent child).

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

- The Covered Person's or Dependent's Medicaid or Children's Health Insurance

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

NOTE: The Covered Person or Dependent must request Special Enrollment within sixty (60) days of the loss of Medicaid/CHIP or of the eligibility determination. To request Special Enrollment or obtain more information, call SHBP Member Services at 1-800-610-1863 or visit the SHBP Enrollment Portal: **mySHBPga.adp.com**.

Women's Health and Cancer Rights Act of 1998

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

administration of the Plan, or to facilitate your receipt of other benefits.

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

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

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

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

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

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

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

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

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: **shbp.georgia.gov**. To request a paper copy, please contact SHBP Member Services at 800-610-1863.

Georgia Law Section 33-30-13 Notice:

SHBP actuaries have determined that the total cost of coverage (which includes the cost paid by the State and the cost paid by members) under all options is 0% higher than it would be if the Affordable Care Act provisions did not apply.

ADDRESSES TO FILE HIPAA COMPLAINTS:

Georgia Department of Community Health SHBP HIPAA Privacy Unit

P.O. Box 1990
Atlanta, GA 30301
1-800-610-1863

U.S. Department of Health & Human Services Office for Civil Rights
Region IV
Atlanta Federal Center

61 Forsyth Street SW Suite 3B70
Atlanta, GA 30303-8909
1-877-696-6775

For more information about these notices, contact

Georgia Department of Community Health
State Health Benefit Plan

P.O. Box 1990
Atlanta, GA 30301
1-800-610-1863

Website for Open Enrollment Available October 16, 2023 at midnight through November 3, 2023 at 11:59 p.m. ET

FOR PLAN COVERAGE EFFECTIVE JANUARY 1, 2024 – DECEMBER 31, 2024

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

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

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