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MY 2026

SHBP RETIREE DECISION GUIDE

RETIREE OPTION CHANGE PERIOD (ROCP)

OCTOBER 20 - NOVEMBER 7, 2025

STATE HEALTH BENEFIT PLAN RESOURCES/CONTACT INFORMATION

Anthem Blue Cross and Blue Shield (Anthem)		
Medicare Advantage (MA) Pre-Enrollment (**First Impressions**): Monday - Friday, 8 a.m. - 8 p.m. ET	855-322-7060	**anthemretiree.com/SHBP**
Medicare Advantage Post-Enrollment (Member Services): Monday - Friday, 8 a.m. - 8 p.m. ET	855-322-7062	
Active Non-MA Member Services: Monday - Friday, 8 a.m. - 8 p.m. ET	855-641-4862 (TTY 711)	**anthem.com/shbp**
Report Fraud: Monday - Friday, 8 a.m. - 8 p.m. ET	855-322-7062	
UnitedHealthcare		
Medicare Advantage (MA) Customer Service: Monday - Friday, 8 a.m. - 8 p.m. ET	877-246-4190	retiree.uhc.com/shbp (MA member website), uhcvirtualretiree.com/shbp (MA member education center website)
Active Non-MA Customer Service: Monday - Friday, 8 a.m. - 8 p.m. ET	888-364-6352 (TTY 711)	whyuhc.com/shbp
Report Fraud: Monday - Friday, 8 a.m. - 8 p.m. ET	877-246-4190	
Kaiser Permanente (KP)		
Active and Pre-65 Retiree (Non-MA) Member Services: Monday - Friday, 7 a.m. - 7 p.m. ET (Appointment Scheduling, Prescriptions, and Nurse Advice Available 24 hours per day/7 days per week)	855-512-5997 (TTY 711)	my.kp.org/shbp
Wellness Program Customer Service Monday - Friday, (Except Holidays) 11 a.m. - 8 p.m. ET	866-300-9867	

STATE HEALTH BENEFIT PLAN RESOURCES/CONTACT INFORMATION

Wellness Program Administrator		
Sharecare Medicare Advantage (MA) Active Non-MA Member Services: Monday - Friday, 8 a.m. - 8 p.m. ET	888-616-6411 (TTY 711)	bewellshbp.com
Corporate Compliance Hotline	844-401-0005 (TTY 711)	
Pharmacy Administrator		
CVS Caremark® Active Non-MA 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 Retiree Option Change Period (ROCP): Monday - Friday, 8:30 a.m. - 7:30 p.m. ET Saturday, 8:30 a.m. - 5 p.m. Regular Business Hours: Monday - Friday, 8:30 a.m. - 5:00 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 per 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.

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Welcome to the State Health Benefit Plan's (SHBP) Retiree Option Change Period (ROCP) for the 2026 Plan Year. ROCP gives you the opportunity to review the plan options and make changes to your coverage based on your needs. Please read this document carefully to ensure you are choosing the option that best meets your and your covered dependents' healthcare needs.

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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 | Dean Burke, MD, 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 Retiree,

Welcome to the **2025 Retiree Option Change Period (ROCP)** for the State Health Benefit Plan (SHBP), administered by the Georgia Department of Community Health. Thank you for your dedicated service to the people of Georgia—as retired teachers, public school employees, and state employees, your contributions have had a lasting impact.

If you elect not to make any changes during the annual Retiree Option Change Period (ROCP), your current coverage will remain in effect for the 2026 Benefit Plan Year. We encourage you to use this opportunity to review your options and choose the coverage that best fits your health needs and budget. Even if you elect not to make changes, it is a good idea to review your current contact and enrollment information to ensure that it is correct.

For the 2026 Plan Year, SHBP is pleased to continue offering the high-quality plan designs available in 2025:

- **For Medicare-eligible retirees (age 65 or older):**
  The **Medicare Advantage Standard and Premium Plan Options** will continue to be offered by **Anthem Blue Cross and Blue Shield** and **UnitedHealthcare**.
- **For pre-65 retirees:**
  We will continue offering:
  - The **Gold, Silver, and Bronze Health Reimbursement Arrangement (HRA) Plans** by **Anthem**
  - The **High-Deductible Health Plan (HDHP)** by **UnitedHealthcare**
  - The **statewide Health Maintenance Organization (HMO) Plans** by **Anthem** and **UnitedHealthcare**
  - The **regional HMO Plan** by **Kaiser Permanente**

How to Make Your Elections

The 2025 ROCP runs from **Monday, October 20, 2025, beginning at 12:00 a.m. ET, through Friday, November 7, 2025, at 11:59 p.m. ET**. You can make your benefit elections in one of two ways:

1. **Online:** Visit the SHBP Enrollment Portal at **mySHBPga.adp.com** for 24/7 access throughout the ROCP period.
2. **By Phone:** Contact **SHBP Member Services** at **800-610-1863** if you prefer to speak with a representative or need assistance with your enrollment.

On behalf of the SHBP team and the Georgia Department of Community Health, thank you once again for your service. We remain committed to supporting your health and well-being in retirement.

Sincerely,

Dean Burke, MD
Commissioner, Georgia Department of Community Health

WELCOME

TO THE RETIREE OPTION CHANGE PERIOD

Greetings,

Welcome to the **2025 Retiree Option Change Period (ROCP)** for the State Health Benefit Plan (SHBP), administered by the Georgia Department of Community Health (DCH). On behalf of the entire SHBP team, thank you for your years of dedicated service as retired teachers, public school employees, and state employees. Your contributions have made a lasting impact on countless Georgians.

The 2025 ROCP begins at 12:00 a.m. ET on Monday, October 20, and ends at 11:59 p.m. ET on Friday, November 7, 2025. During this time, you have the opportunity to continue with your current Plan Option or select a new plan that better meets your healthcare needs and those of your family.

To support you in making the best choice, we encourage you to review the **2026 Retiree Decision Guide**, a valuable resource that includes:

- Detailed descriptions of Plan Options
- Comparison charts
- Key information effective from January 1, 2026, through December 31, 2026

If you choose not to make any changes during the ROCP, your current coverage will automatically remain in place. However, we strongly recommend reviewing your contact and enrollment information to ensure everything is accurate and up to date.

You can also access 2026 plan documents and additional information by visiting our website at **shbp.georgia.gov**.

On behalf of Governor Brian Kemp, DCH Commissioner Dean Burke, MD, the Board of Community Health, and the entire SHBP family, I encourage you to explore your options carefully and select the plan that best suits your individual needs for 2026.

We remain committed to **Shaping the Future of a Healthy Georgia** by providing access to quality, affordable healthcare for our retirees. I look forward to supporting you throughout this process.

Sincerely,

Louis A. Amis
Executive Director, SHBP

2026 Medical Claims Administrators, Plan Options and Enhanced Benefits

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 Plan Options listed below for 2026.

Plan Option Offerings

Medicare Advantage with Prescription Drugs (MAPD) Preferred Provider Organization (PPO) Standard and Premium

- Anthem
- UnitedHealthcare

Health Maintenance Organization (HMO)

- Anthem
- KP (Metro Atlanta Service Area and Athens, 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

2026 WELLNESS INCENTIVES AT-A-GLANCE

See 2026 Wellness section for details (Commercial Plan Options pg. 40)

Active Non-Medicare Advantage Plan Options	Anthem HMO MyIncentive Account (MIA) Credits	Anthem Health Reimbursement Arrangement (HRA) Credits	Kaiser Permanente (KP) Regional HMO	UnitedHealthcare HMO Health Incentive Account (HIA) Credits	UnitedHealthcare HDHP Health Incentive Account (HIA) Credits
Who's Eligible					
Member	480	480	$500 Reward Card	480	480
Spouse	480	480	$500 Reward Card	480	480
UnitedHealthcare Reward Card for member and 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: *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 and their covered spouses enrolled in the KP Regional HMO Plan Option have until November 30, 2026 will each receive a $500 reward card after each covered member satisfies KP's Wellness Program requirements.*

UnitedHealthcare: *Members and their covered spouses enrolled in a UnitedHealthcare Commercial (active non-MA) Plan Option will each receive $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 Visa Prepaid Card through the Sharecare Redemption Center.*

Note: *It is the member's responsibility to consult with their tax advisor to understand the tax implications of accepting a reward or incentive card.*

IMPORTANT PLAN REMINDERS

New Identification Cards

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

Social Security Number or other Taxpayer Identification Number

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

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 for QEs and 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 2025 Points

Anthem Blue Cross and Blue Shield (Anthem) and UnitedHealthcare Commercial (Active Non-MA) Plan Options: Members and their covered spouses currently enrolled in Anthem and UnitedHealthcare Commercial Plan Options who have not completed the required health actions or have not taken any actions have until December 1, 2025, to:

- Complete all required actions,
- Submit the 2025 Physician Screening Form to earn the 2025 well-being incentive credits, and
- Submit all documentation to Sharecare no later than December 1, 2025. Please note that all submissions must be received by Sharecare by this date.

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

Kaiser Permanente: Members and their covered spouses currently enrolled in the KP Regional HMO Plan Option have until November 30, 2025, to complete all five wellness activities to receive a $500 reward card. For additional details, if you have questions or need help getting started, visit KP's website at **my.kp.org/shbp** or contact KP's wellness program customer service at 866-300-9867.

2025 Rollover Credits for Commercial (active non-MA) Plan Options: Regardless of what Plan Option you select, all unused well-being incentive credits earned in 2025 will automatically roll over to the 2026 Plan Option you choose during ROCP. SHBP will deposit your unused credits in the incentive account associated with your 2026 plan selection in April 2026. If you remain with the same Medical Claims Administrator and in the same Plan Option in which you were enrolled in 2025, rollover credits will be available immediately.

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.

2025 Rollover Credits from Commercial (active non-MA) Plan Options to Medicare Advantage Plan Options:

Any unused wellness credits will remain in your Health Reimbursement Arrangement (HRA), Health Incentive Account (HIA), MyIncentive Account (MIA) or Kaiser Permanente Rollover Account (KPRA) for a six-month run-out period, to allow for prior plan's claims processing.

If you have a balance of 100 credits or more in your HRA, HIA, MIA or KPRA after being enrolled in MA for at least six months, and are not in a split option, an individual Retiree Reimbursement Account (RRA) will be set up by your Medicare Advantage Plan Administrator, Anthem or UnitedHealthcare. Credits remain with the Commercial (active non-MA) Plan Option if you have a spouse and/or dependent(s) who is still on that plan. If there are any credits remaining once the last Commercial member moves to MA, the credits will follow that member. Once you move over to a Medicare Advantage Plan Option, you are no longer eligible to earn points with Sharecare.

The MA claims administrators will reimburse you for covered out-of-pocket expenses to the maximum balance in the RRA.

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 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**. Additionally, SHBP members can request copies of the SBCs on the website at **shbp.georgia.gov/sbc-request**.

ACTION **ALERT**

If you or your enrolled dependent(s) experience a Qualifying Event 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 you are 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 the 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 Basic Subsidy Policy if:

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

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

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

Annuitant Years of Service Subsidy Policy (YOS Policy)
Under the 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 YOS 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 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 will provide SHBP information which indicates whether or not a member had five years of service as of January 1, 2012, and if not, each applicable state retirement system will provide SHBP the number of years of service that a member did have upon 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 2026 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.

RETIREE OPTION CHANGE PERIOD AND YOUR RESPONSIBILITIES

The SHBP Enrollment Portal for the ROCP is available from October 20, 2025, at 12 a.m. through November 7, 2025, 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 7, 2025, by 11:59 p.m. ET.
- Read and make sure you understand the plan materials posted at shbp.georgia.gov. Take any required actions.
- Update any change in contact information (i.e., address, email, and phone number) by making the correction online at mySHBPga.adp.com or by calling SHBP Member Services for assistance. Please view the "Skip the Phones" presentation at shbp.georgia.gov for additional instructions on how to update your contact information.
- Check with your applicable State retirement system to ensure the correct amount of SHBP premiums are being deducted from your retirement annuity and submitted to SHBP, if applicable. If SHBP determines that you have not submitted your premium 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.
- Pay all required premiums by the due date if they are not automatically deducted from your retirement annuity.
- Notify SHBP whenever you have a change in covered dependents within 31 days of a Qualifying Event by visiting the SHBP Enrollment Portal at mySHBPga.adp.com or contacting SHBP Member Services.
- Within 3-6 months of you or your dependent(s) turning age 65, you and your covered dependent(s), as applicable, must enroll in Medicare Part B.
- Provide your Medicare Part A (if applicable) and Part B information directly to SHBP for you and your covered dependent(s), if applicable, at least one month prior to you and your covered dependent(s) turning age 65. If you or your covered spouse are actively employed, you and your covered dependent age 65 or older must provide your Medicare Part B information directly to SHBP at least one month prior to your retirement. Medicare Part B information may be provided by visiting the SHBP Enrollment Portal at mySHBPga.adp.com or contacting SHBP Member Services.
- Continue to pay your Medicare Part B premium to Social Security Administration (SSA) if you are enrolled in an SHBP Medicare Advantage (MA) PPO Plan Option and continue to pay your monthly SHBP coverage premiums to SHBP.
- **If you and/or your covered dependent(s) age 65 or older do not enroll in an SHBP MA PPO Plan Option, fail to provide the necessary information for SHBP to enroll you in a MA PPO Plan Option, or lose your eligibility to be enrolled in an SHBP MA PPO Plan Option, you will pay the unsubsidized cost of coverage, which is substantially higher.**
- **Do not enroll in a third-party (non-SHBP) Medicare Advantage Plan, Medicare Part D Plan or Medicare Supplement, or you will lose eligibility for SHBP coverage.**

During ROCP, you may:

- Change to any Plan Option and/or vendor for which you are eligible; however, you cannot add dependents to your coverage
- Drop covered dependents
- Discontinue SHBP coverage

IMPORTANT NOTES:

- **If you discontinue your SHBP coverage for any reason, you will not be able to re-enroll unless you return to work in a benefits-eligible position that offers SHBP benefits.**

- If you return to work in a benefits-eligible position after retiring, you will need to have health insurance premiums deducted from your paychecks as an active member (i.e., eligible employee of an SHBP Employing Entity). Please note, this may not apply to those retired teachers returning to work under HB 385. Upon retiring again, you must notify SHBP Member Services at 800-610-1863 within 31 days to request coverage as a retiree or you will no longer have coverage with SHBP.

- When you retire, generally, your deductions will be taken from your retirement annuity check. If your retirement annuity check does not cover the cost of your premium, exceeds the maximum amount set yearly that SHBP will deduct from retirement annuities, or if an error occurs that prevents SHBP from receiving a premium deduction to cover your SHBP monthly premium, you will be placed on Direct Pay and you should pay any bills that you receive from SHBP to continue your coverage as a retiree. For more information, call SHBP Member Services at 800-610-1863.

- The election made during the 2025 ROCP will be the coverage you have for the entire 2026 Plan Year unless you have a QE that allows a change in your coverage.

- Enrolling in or discontinuing coverage from individual coverage offered through the Health Insurance Marketplace (exchange) is NOT a Qualifying Event.

MAKING YOUR HEALTH BENEFIT ELECTION FOR 2026

The Retiree Option Change Period begins October 20, 2025, midnight ET and ends November 7, 2025, 11:59 p.m. ET

Before making your election, 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 confirm your access to the enrollment portal in advance of the Retiree Option Change Period (ROCP) election start date.**

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 ROCP. Also, confirm that your email address and phone number are correct in the enrollment portal.

How to Reset Your Password

Go to the Enrollment Portal: mySHBPga.adp.com

Step 1: Click **Need help signing in?**
Step 2: Click **Forgot password?**
Step 3: Provide your User ID along with your phone number or email address associated with your account.
Step 4: You will receive either an email or a text message to allow you to reset your password.
Step 5: Click **Continue**

***Note:** Again, due to expected heavy call volume and online traffic, we strongly encourage all members to confirm your access to the enrollment portal before the ROCP.*

What If I Do Not Take Any Action?

If you do not make an election through the SHBP Enrollment Portal or by calling the SHBP Member Services Center, you will automatically be enrolled in the same plan option you had for Plan Year 2025.

- **Currently Enrolled in an SHBP Medicare Advantage Plan Option in 2025:** If you are a current MA Plan member, you remain in the same MA plan option in which you were enrolled in 2025. If you do not want to remain in the same plan, you will need to select from the other available MA Plan options for 2026.
- **Currently Enrolled in an SHBP Commercial (active non-Medicare Advantage) Plan Option in 2025:** If you are enrolled in a Commercial (non-Medicare Advantage) Plan Option in 2025, you will remain in your current Plan Option and tier with the current Medical Claims Administrator for 2026.
- If you are **currently Enrolled in TRICARE Supplement,** you will remain enrolled in the TRICARE Supplement for 2026.

NOTE: If you paid a Tobacco Surcharge in 2025, it will continue to apply. If you did not pay a Tobacco Surcharge in 2025, you will not pay the Surcharge 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) resume(s) tobacco use. You must notify SHBP if your answer to the Tobacco Surcharge question changes.

How to Make Your 2026 Health Benefit Election Online

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

Step 1: Log on to the SHBP Enrollment Portal. The homepage displays a ROCP message on the top of the screen indicating the event date for elections to be in effect for the 2026 Plan Year.

- 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 2026 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 2026 election.

NOTE: You will be able to elect a separate Dependent Health Benefit Option if you are in a Split Option. A Split Option is when you and your covered dependent(s) are not eligible for the same plan option and must be enrolled in different plan options. For example, a member enrolled in an SHBP Medicare Advantage plan with a child under age 65 is able to choose a separate Commercial (active non-MA) plan option for their child since they are not eligible to enroll in an SHBP Medicare Advantage plan. If you are not in a Split Option, you will not be able to make a Dependent Health Benefit election, which means your covered dependent(s) will be enrolled in the same plan option in which you are enrolled in.

Step 2: Under the Open Enrollment tile, **click on Enroll Now** to proceed with your 2026 Plan Year enrollment.

Step 3: If you are enrolled in a Commercial Plan and you have not provided a Tobacco Survey in the past, you must first answer the Tobacco Survey 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 or other Taxpayer Identification Number.

NOTE: You can only add a dependent(s) if you have a Qualifying Event. For existing dependents, confirm that all dependents requiring benefits have a check in the "Include in Coverage" box.

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

Step 6: **Select Change Plan.** After you Select Change Plan, 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.**

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

Step 10: **Click I Agree and Confirm Elections.** If "I Agree and Confirm Elections" is NOT clicked, your enrollment process has not been completed.

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

To help you with your enrollment choices, SHBP includes 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 the Decision Support Tool.

RETIREE OPTION CHANGE PERIOD 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 log on and make elections multiple times. However, the last option confirmed at the close of ROCP will be your option for 2026, unless you experience a Qualifying Event 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 benefit elections under the Flexible Benefits Program administered by the Department of Administrative Services, please visit GABreeze.ga.gov or call 877-342-7339.

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

The election made during the 2025 Retiree Option Change Period (ROCP) will be the coverage you have for the entire 2026 Plan Year, unless you have a Qualifying Event (QE) that allows a change in your coverage. You 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 and Enrollment Provisions document available online at shbp.georgia.gov. You may also contact SHBP Member Services 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 QE in the SHBP Enrollment Portal on, but no earlier than, the date on which the event actually occurs. For example, if your spouse loses coverage with their current employer on November 30, 2025, you cannot declare the QE in the Enrollment Portal until November 30, 2025 (i.e., date of the event). If you do not declare the QE in the Enrollment Portal within 31 days of November 30, 2025 (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 31 days of the QE and a representative 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.

2026 SHBP Medicare Advantage with Prescription Drugs Preferred Provider Organization Plan Options

The 2026 SHBP Medicare Advantage (MA) Plan Options include:

- Anthem Blue Cross and Blue Shield MAPD PPO Standard
- Anthem Blue Cross and Blue Shield MAPD PPO Premium
- UnitedHealthcare MAPD PPO Standard
- UnitedHealthcare MAPD PPO Premium

SHBP's MA Plan Options are plans approved by the Centers for Medicare & Medicaid Services (CMS); they are sometimes called Part C Plans. These plans take the place of your original **Medicare Part A – Hospital, Medicare Part B – Medical and Medicare Part D – Prescription Drug benefit**. These plans are very similar to traditional PPO plans. You may receive benefits from in-network and out-of-network providers as long as the provider has not opted out of Medicare, and they accept and bill the MAPD Plans.

SHBP's MA PPO Plan Options also provide contracted networks on a statewide and national basis. You will have the choice of a MA PPO Standard or Premium plan under Anthem Blue Cross and Blue Shield or UnitedHealthcare. Additionally, you can see non-contracted providers as long as they have not opted out of Medicare, and they accept and bill the MAPD Plans.

- You do not have to select a Primary Care Physician or obtain a referral to see a Specialist.
- Medical Co-pays apply toward the medical out-of-pocket maximum and Pharmacy copays apply to the Part D prescription drug out of pocket maximum.
- Unlike traditional PPO plans, there is no difference in your co-pay/co-insurance levels if you see providers who are contracted (in-network) or providers who are not contracted (out-of-network). So, you are not penalized for going to a non-contracted provider that accepts Medicare and the MAPD Plans.
- There will be **no coverage** if you see a provider who does not accept Medicare.
- Enrollment in the MAPD PPO plans is subject to CMS approval and is prospective (retroactive enrollment is generally not allowed).
- **CMS requires a physical street address** and a Medicare Beneficiary Identifier before approving MAPD PPO coverage.
- Once your enrollment is approved by CMS, CMS will notify the State Health Benefit Plan of the effective date of your coverage.
- You must show your Anthem or UnitedHealthcare ID card, as applicable, in place of your Medicare card when receiving medical services and prescription drugs.

NOTE: When your covered dependent(s) is not eligible to participate in an SHBP MAPD option, you and your covered dependent(s) must enroll in a Split Option. A Split Option is where you and your covered dependents must be enrolled in different Plan Options.

IF YOU OR YOUR COVERED DEPENDENT(S) ARE AGE 65 OR OLDER AND...	THEN...
• You fail to provide your and/or your covered dependent's Part A (if applicable) and Part B information directly to SHBP one month prior to you and/or your covered dependent turning Age 65; • You fail to provide your and/or your covered dependent's Part A (if applicable) and Part B information directly to SHBP one month prior to your retirement (if currently working and covered as an active member);	You and/or your covered dependent(s) will remain enrolled in an SHBP Commercial (active non-MA) Plan Option (i.e., the Gold, Silver or Bronze HRA; one of the HMOs; or the HDHP) and you will pay 100% of the unsubsidized premium, which is substantially higher than the SHBP Medicare Advantage Plan Options.
• You or your covered dependent(s) do not have a physical address on file, • You or your covered dependent(s) enroll in a third-party (non-SHBP) Medicare Advantage Plan, Medicare Part D Plan or Medicare Supplement, or • You or your covered dependent(s) lose your Medicare Part B for any reason	You and/or your covered dependent's Medicare Advantage with Prescription Drugs (MAPD) coverage under SHBP will be terminated and SHBP will move you to a Commercial (active non-MA) Plan Option (i.e., the Gold, Silver or Bronze HRA; one of the HMOs; or the HDHP) and you will pay 100% of the unsubsidized premium, which is substantially higher than the SHBP Medicare Advantage Plan Options.
• You or your covered dependent(s) are without Medicare Part B	You and/or your covered dependent(s) will remain enrolled in or be enrolled in an SHBP Commercial (active non-MA) Plan Option (i.e., the Gold, Silver or Bronze HRA; one of the HMOs; or the HDHP) and you will pay 100% of the unsubsidized premium, which is substantially higher than the SHBP Medicare Advantage Plan Options; -OR- You or your covered dependent(s) may purchase Part B to enroll in a MAPD option; however, you will be responsible for paying the Late Enrollment Penalty if you are enrolling late in Medicare after your Initial Enrollment Period prescribed by CMS for Medicare Parts A and/or B.

Note: Enrollment in an SHBP Medicare Advantage Plan Option is prospective after any of the above circumstances. Until you are enrolled in an SHBP Medicare Advantage Plan Option, you will remain enrolled in an SHBP Commercial (active non-MA) Plan Option and pay 100% of the unsubsidized premium, which is substantially higher than the SHBP Medicare Advantage Plan Options.

BENEFITS COMPARISON SUMMARY:

SHBP MEDICARE ADVANTAGE STANDARD AND PREMIUM PLAN OPTIONS

Standard and Premium Plans | January 1 – December 31, 2026

	MAPD – Standard Anthem/UnitedHealthcare	MAPD – Premium Anthem/UnitedHealthcare
Covered Services	**You Pay**	**You Pay**
Deductibles	$0	$0
Out-of-Pocket Maximum Per Member[1]	$3,500 per member	$2,500 per member
Physicians' Services	**You Pay**	**You Pay**
Primary Care Physician or Specialist Office or Clinic Visits Treatment of illness or injury	PCP—$25 per office visit co-pay; SPC—$30 per office visit co-pay	PCP—$15 per office visit co-pay; SPC—$25 per office visit co-pay
Primary Care Physician or Specialist Office or Clinic Visits Annual Wellness Visit	$0 co-pay	$0 co-pay
Telemedicine/Virtual visit (if not thru LiveHealth Online, you will be charged the appropriate copay for PCP or specialist visit	$0 co-pay	$0 co-pay
Complex Radiology Services and Radiation Therapy Received in a Doctor's Office[2] (Doctor's office visit co-pay will apply)	$35 co-pay	$35 co-pay
Diagnostics Procedures and Testing Services Received in a Doctor's Office (Doctor's office visit co-pay will apply)	$0 co-pay	$0 co-pay
Annual Screenings **Note:** Pap smears are covered every 24 months unless high risk, then annually	$0 co-pay (mammograms, cervical, prostate, and colorectal cancer screenings)	$0 co-pay (mammograms, cervical, prostate, and colorectal cancer screenings)
Hospital Services	**You Pay**	**You Pay**
Inpatient Hospital Services	20% co-insurance	20% co-insurance
Outpatient Hospital Services (Includes observation, medical and surgical care)	$95 co-pay Observation Room $25 co-pay PCP $30 co-pay SPC	$50 co-pay Observation Room $15 co-pay PCP $25 co-pay SPC
Complex Radiology Service and Radiation Therapy Service[2] (When the service is performed at a hospital, outpatient facility or a freestanding imaging or diagnostic center)	20% co-insurance	20% co-insurance
Diagnostic Procedures and Testing Services (When the service is performed at a hospital, outpatient facility or a freestanding imaging or diagnostic center)[3]	$95 co-pay	$50 co-pay

[1] Not all covered services apply to the out-of-pocket maximum. Contact Anthem or UnitedHealthcare for details.

[2] The diagnostic radiology services require specialized equipment beyond standard X-ray equipment and must be performed by specially trained or certified personnel. Examples include, but are not limited to, specialized scans, CT, SPECT, PET, MRI, MRA, nuclear studies, sonograms, diagnostic mammograms and interventional radiological procedures (angiogram and barium studies).

[3] Other co-pays may apply.

BENEFITS COMPARISON SUMMARY:

SHBP MEDICARE ADVANTAGE STANDARD AND PREMIUM PLAN OPTIONS

Standard and Premium Plans | January 1 – December 31, 2026 (continued)

	MAPD PPO – Standard Anthem/UnitedHealthcare	MAPD PPO – Premium Anthem/UnitedHealthcare
Behavioral Health	**You Pay**	**You Pay**
Mental Health and Substance Abuse Inpatient Facility	20% co-insurance	20% co-insurance
Mental Health and Substance Abuse Outpatient Visits	$30 co-pay Professional Individual & Group Therapy Visits $55 co-pay Professional Partial Hospitalization Visits	$25 co-pay Professional Individual & Group Therapy Visits $50 co-pay Professional Partial Hospitalization Visits
Dental (Medicare covered)	**You Pay**	**You Pay**
Dental and Oral Care (Routine Dental not covered)	$25 per office visit co-pay for Medicare covered dental services	$15 per office visit co-pay for Medicare covered dental services
Vision	**You Pay**	**You Pay**
Routine Eye Exam NOTE: Limited to one eye exam every 12 months including refraction exam	Co-pay per office visit: Anthem ($0); UHC ($0) — limited to one annual eye exam; $125 eyewear benefit (glasses/ frames or contact lenses) allowance: Anthem (every calendar year)[1]; UHC (every 12 months)[1]	Co-pay per office visit: Anthem ($0); UHC ($0) — limited to one annual eye exam; $125 eyewear benefit (glasses/ frames or contact lenses) allowance: Anthem (every calendar year)[1]; UHC (every 12 months)[1]
Emergency Coverage	**You Pay**	**You Pay**
Ambulance Services (land or air ambulance to nearest facility to treat the condition)	$50 co-pay	$50 co-pay
Emergency Care	$50 co-pay; waived if admitted to hospital within 72 hours for the same condition	$50 co-pay; waived if admitted to hospital within 72 hours for the same condition
Urgent Care Services	$25 co-pay; waived if admitted to hospital within 72 hours for the same condition	$20 co-pay; waived if admitted to hospital within 72 hours for the same condition
Other Coverage	**You Pay**	**You Pay**
Home Health Care Services	$0 co-pay per visit	$0 co-pay per visit
Hearing Services and Hearing Aids Routine hearing exam	$0 co-pay limited to one exam every 12 months; $1,000 hearing aid allowance every 4 calendar years; UHC every 4 years	$0 co-pay limited to one exam every 12 months; $1,000 hearing aid allowance every 4 calendar years; UHC every 4 years
Skilled Nursing Facility Services (Prior authorization required)	$0 co-pay per day for days 1–20; $50 co-pay per day for days 21–100 for up to 100 days per benefit period (no prior hospital stay required)	$0 co-pay per day for days 1-20; $25 co-pay per day for days 21-100 for up to 100 days per benefit period (no prior hospital stay required)

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

BENEFITS COMPARISON SUMMARY:

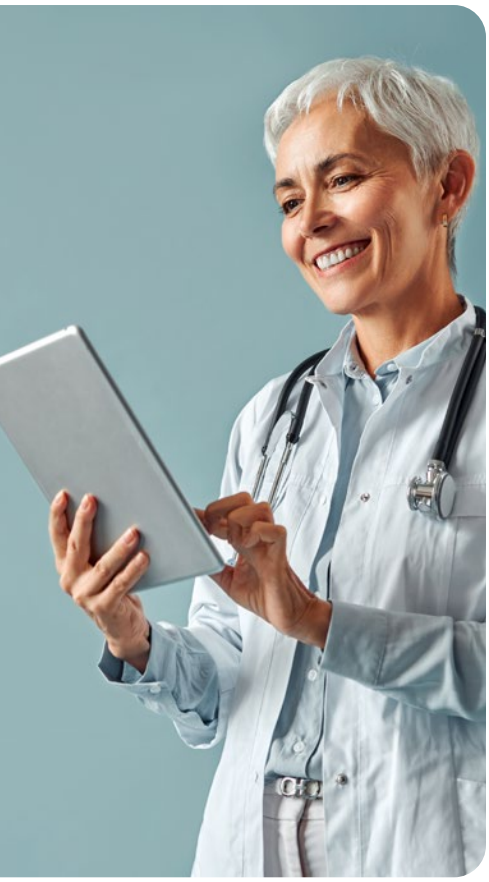
SHBP MEDICARE ADVANTAGE STANDARD AND PREMIUM PLAN OPTIONS

Standard and Premium Plans | January 1 – December 31, 2026 (continued)

	MAPD PPO – Standard Anthem/UnitedHealthcare	MAPD PPO – Premium Anthem/UnitedHealthcare
Other Coverage	**You Pay**	**You Pay**
Hospice Care	100% coverage; must receive care from a Medicare covered hospice facility (no prior approval required). For services not related to the terminal condition member cost-shares may apply.	100% coverage; must receive care from a Medicare covered hospice facility; (no prior approval required). For services not related to the terminal condition member cost-shares may apply.
Durable Medical Equipment (DME) Prior approval required for certain DME.	20% co-insurance for Medicare covered items.	20% co-insurance for Medicare covered items.
Outpatient Acute Short-Term Rehabilitation Services • Physical Therapy • Speech Therapy • Occupational Therapy • Cardiac Therapy • Pulmonary Therapy	$25 co-pay per office visit for Medicare covered services	$10 co-pay per office visit for Medicare covered services
Chiropractic Care	Medicare covered: $18 co-pay per office visit; No visit limit. Routine Non-Medicare covered: Anthem - $18 co-pay per office visit; UHC - $30 co-pay per office visit; limit of 20 visits per year.	Medicare covered: $18 co-pay per office visit; No visit limit. Routine Non-Medicare covered: Anthem - $18 co-pay per office visit; UHC - $25 co-pay per office visit; limit of 20 visits per year.
Foot Care	Medicare covered: UHC $30 co-pay per office visit; Routine Non-Medicare covered: Anthem $25 co-pay; limit of visits per year: UHC (6) and Anthem (12)	Medicare covered: UHC $25 co-pay per office visit; Routine Non-Medicare covered: Anthem $15 co-pay Medicare covered; limit of visits per year: UHC (6) and Anthem (12)
Pharmacy	**You Pay**	**You Pay**
Select Generic Co-pay	$0 retail or mail order	$0 retail or mail order
Tier 1 Co-pay	$15 retail—31-day supply; $37.50 mail order—100-day supply	$15 retail—31-day supply; $37.50 mail order—100-day supply
Tier 2 Co-pay	$45 retail—31-day supply; $112.50 mail order—100-day supply	$45 retail—31-day supply; $112.50 mail order—100-day supply
Tier 3 Co-pay	$85 retail—31-day supply; $212.50 mail order— 100-day supply	$85 retail—31-day supply; $212.50 mail order— 100-day supply
Tier 4 Co-pay	$85 retail—31-day supply; $212.50 mail order— 100-day supply	$85 retail—31-day supply; $212.50 mail order— 100-day supply

Once you have reached the yearly $2,100 true out-of-pocket (TROOP), the plan pays for the full cost of your covered drugs-you pay nothing.

***NOTE:** While the co-pay amounts are not changing for 2026, you may want to check to see if the medications you are taking have changed tiers for 2026.*



2026 SHBP COMMERCIAL (ACTIVE NON-MEDICARE ADVANTAGE) PLAN OPTIONS

SHBP Pre-65 retirees 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 31 counties within the Metro Atlanta Service Area to be eligible to enroll in KP:

Barrow	Clayton	Fayette	Henry	Oglethorpe	Walton
Bartow	Cobb	Forsyth	Lamar	Paulding	
Butts	Coweta	Fulton	Madison	Pickens	
Carroll	Dawson	Gwinnett	Meriwether	Pike	
Cherokee	DeKalb	Haralson	Newton	Rockdale	
Clarke (Athens)	Douglas	Heard	Oconee	Spalding	

Note: SHBP members age 65 or older who do not elect an SHBP MA Plan Option and/or are not eligible or have covered dependents who are not eligible for an SHBP MA Plan Option can select an SHBP Commercial (active non-MA) Plan Option. However, you will pay the higher, unsubsidized cost of the coverage.

Additional Option

The TRICARE Supplement will continue to be available for those members enrolled in TRICARE. See “Alternative Coverage” section on page 39 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 services.

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 2026 action-based health incentives that will allow these SHBP members and their covered spouses to earn additional points.

Understanding Your Plan Options For 2026

How the Health Reimbursement Arrangement With Anthem Blue Cross and Blue Shield 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.

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 2025, 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 2025 well-being incentive credits will roll over to your 2026 HRA plan, or any other Plan Option, in April 2026.

NOTE: There is a date limitation to how the 2025 rollover credits can be used for reimbursement. Only eligible medical and pharmacy expenses incurred after the rollover in April 2026 will qualify for reimbursement using the 2025 rollover credits. Eligible medical and pharmacy expenses incurred between January and March 2025 are not eligible for reimbursement using 2025 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 2026. However, until your unused 2025 credits roll over, your 2026 HRA credits funded by SHBP, and any well-being incentive credits earned in 2025 (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.
- 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.
- You do not have to obtain a referral to see a Specialist (SPC); however, we encourage you to select a Primary Care Physician (PCP) to help coordinate your care.
- The medical and pharmacy out-of-pocket maximums are combined.
- The credits in your HRA account are used to help meet your deductible and your out-of-pocket maximums.
- There are no co-pays.
- Certain drug costs are waived if SHBP is primary and you actively participate in one of the Disease Management (DM) Programs for diabetes, asthma, and coronary artery disease.
- If you enroll in the HRA Plan Option after the first of the year, your SHBP-funded base credits deposited into your HRA account will be prorated. However, your deductible and co-insurance will not be prorated.
- The Plan pays 100% of covered services provided by in-network providers that are properly coded as “preventive care” within the meaning of the Affordable Care Act (ACA).
- Telemedicine/virtual visits for certain medical and behavioral health services are available.

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 networks of providers statewide and on a national basis. 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 tax deferred through payroll deductions to help offset your plan costs.

For members and their covered spouses enrolled in a UnitedHealthcare Plan Option, please see the 2026 Wellness section (page 40) for more information about the additional $250 Reward Card offered through UnitedHealthcare.

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 the dependent's 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 who 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 Primary Care Physician (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 ($1,700 individual; $3,400 other tiers).
- Certain drug costs are waived if SHBP is primary and you actively participate in one of the Disease Management (DM) Programs for diabetes, asthma, and coronary artery disease. Members must satisfy the deductible threshold ($1,700 individual; $3,400 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 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 rollover each plan year
- Investment options are available with a minimum balance and interest accrues on a tax-free basis
- Contributions can start, stop or change anytime
- Distributions cover qualified medical expenses as defined under Section 213(d) of the Internal Revenue Code and certain other expenses
- Tax form 1099 SA and 5498 are sent to employees for filing
- Employees enrolled in the HDHP can have pretax contributions to their Health Savings Accounts (HSA) though payroll deductions.

**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.

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 Primary Care Physician (PCP) to help coordinate your care.
- Coverage is only available when using in-network providers (except for emergency care).
- The Plan pays 100% of covered services provided by in-network providers that are properly coded as "preventive care" within the meaning of the Affordable Care Act (ACA).
- Co-pays count toward your out-of-pocket maximum.
- Co-pays do not count toward your deductible.
- The medical and pharmacy out-of-pocket maximums are combined.
- Certain drug costs are waived if SHBP is primary and you actively participate in one of the Disease Management Programs (DM) for diabetes, asthma, and coronary artery disease.
- 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 31 counties within the Metro Atlanta Service Area listed below.

Barrow	Cobb	Fulton	Meriwether	Rockdale
Bartow	Coweta	Gwinnett	Newton	Spalding
Butts	Dawson	Haralson	Oconee	Walton
Carroll	DeKalb	Heard	Oglethorpe	
Cherokee	Douglas	Henry	Paulding	
Clarke (Athens)	Fayette	Lamar	Pickens	
Clayton	Forsyth	Madison	Pike	

Choose your own Primary Care Physician (PCP) from a network of carefully-selected Kaiser Permanente providers in 26 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, visit my.kp.org/shbp or call Kaiser Permanente 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-Medicare Advantage) Plan Options

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

Benefits Comparison Summary:

HRA Plans | January 1 - December 31, 2026

	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	60% coverage; subject to deductible	80% coverage; not subject to deductible	60% coverage; subject to deductible	75% coverage; not subject to deductible	60% coverage; subject to deductible

Benefits Comparison Summary:

HMO and HDHP Plans | January 1 - December 31, 2026

	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 are not applicable/available for this plan.				
Physician 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 - December 31, 2026

	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
Physician 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 with an office visit	85% coverage; subject to deductible	60% coverage; subject to deductible	80% coverage; subject to deductible	60% coverage; subject to deductible	75% coverage; subject to deductible	60% coverage; subject to deductible
Outpatient Surgery/Services • When billed as an outpatient surgery at a facility; including charges by surgeon, anesthesiologist, pathologist and radiologist	85% coverage; subject to deductible	60% coverage; subject to deductible	80% coverage; subject to deductible	60% coverage; subject to deductible	75% coverage; subject to deductible	60% coverage; subject to deductible
Hospital Services	**The Plan Pays**		**The Plan Pays**		**The Plan Pays**	
Inpatient Services • Inpatient care, delivery and inpatient short-term acute rehabilitation services	85% coverage; subject to deductible	60% coverage; subject to deductible	80% coverage; subject to deductible	60% coverage; subject to deductible	75% coverage; subject to deductible	60% coverage; subject to deductible
Inpatient Services • Well newborn care	85% coverage; subject to deductible	60% coverage; subject to deductible	80% coverage; subject to deductible	60% coverage; subject to deductible	75% coverage; subject to deductible	60% coverage; subject to deductible
Outpatient Surgery/Services • At a hospital or other facility	85% coverage; subject to deductible	60% coverage; subject to deductible	80% coverage; subject to deductible	60% coverage; subject to deductible	75% coverage; subject to deductible	60% coverage; subject to deductible
Hospital Emergency Room Care • Treatment of an emergency medical condition or injury	85% coverage; subject to in-network deductible		80% coverage; subject to in-network deductible		75% coverage; subject to in-network deductible	
Outpatient Testing, Lab, etc.	**The Plan Pays**		**The Plan Pays**		**The Plan Pays**	
Non-Routine Laboratory; X-Rays, Diagnostic Tests, Injections • Including medications covered under medical benefits--for the treatment of an illness or injury **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 - December 31, 2026

	Anthem / UnitedHealthcare Statewide HMO Option	UnitedHealthcare HDHP Option		KP Regional HMO Option
	In-Network Only	In-Network	Out-of-Network	In-Network Only
Physician 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 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 outpatient surgery at a facility, including charges by surgeon, anesthesiologist, pathologist and radiologist	80% coverage; subject to deductible	70% coverage; subject to deductible	50% coverage; subject to deductible	100% coverage after $100 co-pay
Hospital Services	**The Plan Pays**	**The Plan Pays**		**The Plan Pays**
Inpatient Services • Inpatient care, delivery and inpatient short-term acute rehabilitation services	80% coverage; subject to deductible	70% coverage; subject to deductible	50% coverage; subject to deductible	100% coverage after $250 co-pay
Inpatient Services • Well newborn care	100% coverage; not subject to deductible	70% coverage; subject to deductible	50% coverage; subject to deductible	100% coverage
Outpatient Surgery/Services • At a hospital or other facility	80% coverage; subject to deductible	70% coverage; subject to deductible	50% coverage; subject to deductible	100% coverage after $100 co-pay
Hospital Emergency Room Care • Treatment of an emergency medical condition or injury	100% coverage after $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 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 free-standing imaging center $100 co-pay at outpatient hospital facility

Benefits Comparison Summary:

HRA Plans | January 1 - December 31, 2026

	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.	100% coverage; not subject to deductible Out-of-network eye exam not covered		100% coverage; not subject to deductible Out-of-network eye exam not covered		100% coverage; not subject to deductible Out-of-network eye exam not covered	
Hearing Services Routine Hearing Exam when properly coded as preventive	100% coverage	Not covered	100% coverage	Not covered	100% coverage	Not covered
Hearing Services Non-routine hearing not performed in an office setting	85% coverage; subject to deductible	60% coverage; subject to deductible	80% coverage; subject to deductible	60% coverage; subject to deductible	75% coverage; subject to deductible	60% coverage; subject to deductible
Hearing Aid: Adults Fittings	85% coverage for exam and fittings (subject to deductible); $1,500 hearing aid allowance every five years (not subject to deductible)		80% coverage for exam and fittings (subject to deductible); $1,500 hearing aid allowance every five years (not subject to deductible)		75% coverage for exam and fittings (subject to deductible); $1,500 hearing aid allowance every five years (not subject to deductible)	
Hearing Aid: Children (Up to age 19) Fittings	85% coverage for exam and fittings (subject to deductible); $3,000 hearing aid allowance 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 - December 31, 2026

	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% coverage	70% coverage; subject to deductible	50% coverage; subject to deductible	100% after $35 SPC co-pay $17 co-pay for group therapy 100% at partial hospitalization Contact KP directly for additional benefit coverage
MH/SUD Office Visits: Professional and Methadone Clinics	100% after $35 PCP co-pay $35 SPC co-pay $10 co-pay for group therapy	70% coverage; subject to deductible	50% coverage; subject to deductible	100% after $35 PCP co-pay $35 SPC co-pay $17 co-pay for group therapy Contact KP directly for additional 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 year with a diagnosis or diabetes.	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	100% coverage for exam and fittings; subject to deductible $1,500 hearing aid allowance every five years; 100% 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 the deductible	100% coverage for exam and fittings; subject to deductible $3,000 hearing aid allowance per hearing impaired ear every four years; 100% subject to the 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 - December 31, 2026

	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; 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
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 - December 31, 2026

	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/SPC co-pay for services provided in an office. 100% coverage for all other service locations.	70% coverage; subject to deductible	50% coverage; subject to deductible	100% after $35 PCP co-pay $35 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% in-network coverage; up to 120 days per Plan Year	70% coverage; up to 120 days per Plan Year; subject to deductible	Not Covered	100% in-network coverage; up to 120 days per Plan Year
Hospice Care **NOTE:** Prior approval required.	100% coverage	70% coverage; subject to deductible	50% coverage; subject to deductible	100% coverage
Durable Medical Equipment (DME) - Rental or purchase **NOTE:** Prior approval required for certain DME.	100% coverage	70% coverage; subject to deductible	50% coverage; subject to deductible	100% coverage
Transplant Services **NOTE:** Prior approval required.	Contact the Medical Claim Administrator for coverage details.			

Benefits Comparison Summary:

HRA and Pharmacy Plans | January 1 - December 31, 2026

	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% ($5 min/$10 max); not subject to deductible		15% ($5 min/$10 max); not subject to deductible		15% ($5 min/$10 max); not subject to deductible	
Tier 2 **NOTE:** per 31-day maximum supply.	25% ($55 min/$85 max); not subject to deductible		25% ($55 min/$85 max); not subject to deductible		25% ($55 min/$85 max); not subject to deductible	
Tier 3 **NOTE:** per 31-day maximum supply.	25% ($85 min/$130 max); not subject to deductible		25% ($85 min/$130 max); not subject to deductible		25% ($85 min/$130 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% ($12.50 min/$25 max) Tier 2 - 25% ($137.50 min/$212.50 max) Tier 3 - 25% ($212.50 min/$325 max)		Tier 1 - 15% ($12.50 min/$25 max) Tier 2 - 25% ($137.50 min/$212.50 max) Tier 3 - 25% ($212.50 min/$325 max)		Tier 1 - 15% ($12.50 min/$25 max) Tier 2 - 25% ($137.50 min/$212.50 max) Tier 3 - 25% ($212.50 min/$325 max)	

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

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

***NOTE:** If you 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 in addition to the difference between the Brand and Generic Drug costs.*

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

NOTE: Co-pay/co-insurance rates have changed for 2026. You can save even more now by using tier 1 generic products!

Benefits Comparison Summary:

HMO and HDHP Plans | January 1 - December 31, 2026

	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.	$5 co-pay	70% coverage; after deductible is met		$20 co-pay
Tier 2 **NOTE:** per 31-day maximum supply. KP per 30-day max.	$55 co-pay	70% coverage; after deductible is met		$50 co-pay
Tier 3 **NOTE:** per 31-day maximum supply. KP per 30-day max.	$95 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 - $12.50 Tier 2 - $137.50 Tier 3 - $237.50 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).*

***NOTE:** 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.*

***NOTE:** The HDHP Plan 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.

***NOTE:** For the Anthem and UnitedHealthcare plans, if you or your physician requests 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.*

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

NOTE: Co-pay/co-insurance rates have changed for 2026. You can save even more now by using tier 1 generic products!

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 Retired National Guard and Retired 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, 2026 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 www.shbp.georgia.gov.

2026 WELLNESS

Wellness for Members Enrolled in Anthem Blue Cross and Blue Shield (Anthem) and UnitedHealthcare Commercial (Active Non-Medicare Advantage) 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 and well-being. If you want to take big steps toward improved well-being or just a small step in the right direction, Sharecare can help. The program is confidential, voluntary and offered at no additional cost to you.

The Sharecare team will provide you with the support, tools, and lifestyle management information you need to improve your health and well-being. The types of support you can 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, tobacco cessation, and encourage healthy eating habits. These programs are designed to evolve to meet the needs of participants and include:

- **Unwinding by Sharecare:** 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 the program site at **BeWellSHBP.com** or call 888-616-6411.

2026 Well-Being Activities for Anthem and UnitedHealthcare Commercial (Active Non-Medicare Advantage) 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 Visa® Prepaid Card (when redeeming all 480 points earned in 2026) 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 2026 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, 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 40 points for each completed screening exam, up to two times. • Screenings should be completed by August 31, 2026. • For screenings completed in September, October, and November, members can self-attest by November 30, 2026.
January 1 - May 31 Coaching and Challenges	**Coaching and Challenges** 30 points each, 120 points maximum Between January 1 and May 31, complete up to: • 4 telephonic coaching sessions (maximum of 1 coaching session per calendar month - up to 120 points) • 4 challenges (up to 120 points) – Challenges include: **January Challenge:** Food for Thought **February Challenge:** Quit Sugary Drinks **March Challenge:** Healthy Breakfast **April Challenge:** Steps **May Challenge:** Stress Less
June 1 - November 30 Coaching and Challenges	**Coaching and Challenges** 30 points each, 120 points maximum Between June 1 and November 30, complete up to: • 4 telephonic coaching sessions (maximum of 1 coaching session per calendar month - up to 120 points) • 4 challenges (up to 120 points) – Challenges include: **June Challenge:** Hydrating in June **July Challenge:** Relax Your Mind **August Challenge:** Good Night Sleep **September Challenge:** Steps **October Challenge:** Harvest your Savings **November Challenge:** Harmony for the Holidays

*All actions must be completed and appropriate documentation submitted and received by Sharecare between January 1, 2026 and November 30, 2026. This includes the Biometric Screening, which can be completed through your physician by filling out the 2026 Physician Screening Form, 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 November 30, 2026.

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 2026 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, 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

For points earned through Sharecare, after you choose to redeem your points with the Sharecare Redemption Center for well-being incentive credits to apply toward eligible medical and pharmacy expenses (which you may do so in increments of 120, up to a maximum of 480), credits will be available within 30 days of redemption and will be deposited into your MIA, HRA, or HIA account. See 2026 Well-Being Incentives for Anthem and UnitedHealthcare Commercial (active Non-Medicare Advantage) Plan Options Chart for details.

Plan Option	Account Type	When You Must Redeem Your Points for Incentive Credits	How Your Incentive Credits Work
Anthem HRA	Health Reimbursement Arrangement (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 2026 must be redeemed through Sharecare's Redemption Center (points will not be sent automatically to your health plan).	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.
Anthem HMO	MyIncentive Account (MIA)	All points earned in 2026 must be redeemed through Sharecare's Redemption Center (points will not be sent automatically to your health plan).	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 along with a MIA Summary.
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 480 points through the Sharecare Redemption Center. All points earned in 2026 must be redeemed through Sharecare's Redemption Center (points will not be sent automatically to your health plan).	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 through the Sharecare Redemption Center. All points earned in 2026 must be redeemed through Sharecare's Redemption Center (points will not be sent automatically to your health plan).	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: $1,700 You + Child(ren): $3,400 You + Spouse: $3,400 You + Family: $3,400 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 Members Enrolled in the Kaiser Permanente Regional HMO Plan Option

The State Health Benefit Plan (SHBP) is excited to continue to partner with Kaiser Permanente (KP). They offer a comprehensive and integrated team approach to wellness. In addition, KP provides a variety of wellness tools and resources and an incentive program designed to empower you to take an active role in your own health. You will have access to KP's tools, activities and services such as: the Total Health Assessment, biometric screenings, and online and on-site 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 2025 that have unused incentive credits earned in SHBP's *Be Well SHBP®* program administered by Sharecare. The balance will roll over in April 2026. With the KPRA, members will be able to use those unused credits for eligible medical and pharmacy expenses incurred after April 2026, while insured under the KP Regional HMO plan. If you have questions regarding your KPRA, contact KPRA customer service after April 2026 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 KP Prescription Drug Card. To maximize your pharmacy benefits, you should use this card at KP pharmacies to pay your co-pay(s) at the point of sale. Although the KP prescription card is accepted outside of the KP network, you will have to pay the full cost of the drug as this is not a covered benefit under your Plan.

2026 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 their 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, 2026 and November 30, 2026.

	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 credits 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 workout 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. The questionnaire is confidential and only 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 willpower you've got. But quitting for good is absolutely possible. Both Sharecare and KP offer comprehensive online and telephonic tobacco cessation services that provide the tools and support you need to quit successfully. Both programs are confidential, voluntary and are at no additional cost to you. To learn more, members enrolled in Anthem and UnitedHealthcare should visit **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 (including vapes and electronic cigarettes).

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 2025 by completing the Tobacco Surcharge Removal Requirements in the Tobacco Users Cessation Policies for Anthem, UnitedHealthcare and KP at: **shbp.georgia.gov**.

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 their covered dependents) or imposing liability to the SHBP for fraud for indemnification (requiring payment for benefits to which the participant or their 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 their 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 healthcare 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.

ADDRESSES TO FILE HIPAA COMPLAINTS:

Georgia Department of Community Health SHBP HIPAA Privacy Unit

P.O. Box 92150
Atlanta, GA 30314
1-800-610-1863

U.S. Department of Health & Human Services Office for Civil Rights Centralized Case Management Operations

200 Independence Avenue, S.W.
Room 509F HHH Bldg.
Washington, DC 20201
Customer Response Center: 1-800-368-1019
TDD: 1-800-537-7697
Email: ocrmail@hhs.gov

For more information about this Notice, contact

Georgia Department of Community Health
State Health Benefit Plan

P.O. Box 92150
Atlanta, GA 30314
1-800-610-1863

CMS Medicare Part D Creditable Coverage Notice

Important Notice from the Department of Community Health about Your 2026 Prescription Drug Coverage under the State Health Benefit Plan and Medicare for Plan Year: January 1 – December 31, 2026

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

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

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

1. Medicare Prescription Drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers Prescription Drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

2. The Department of Community Health has determined that the Prescription Drug coverage offered under SHBP is, on average for all plan participants, expected to pay out as much as standard Medicare Prescription Drug coverage pays and is, therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

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

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

If you decide to join a Medicare drug plan, your current SHBP coverage will be affected. For those individuals who elect Part D coverage, coverage under the SHBP MA Plan Option will end for the individual.

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

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

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

If you go sixty-three (63) continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go 19 months without creditable coverage, your

CMS Medicare Part D Creditable Coverage Notice

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premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare Prescription Drug coverage. In addition, if you don't join within 63 continuous days after your current coverage ends, you may have to wait until the following October to join.

For More Information About This Notice Or Your Current Prescription Drug Coverage

Contact your Pharmacy Administrator at the number listed on the back of your insurance ID card or SHBP Member Services at 800-610-1863 and select the appropriate prompt to be connected to your Pharmacy Administrator.

Note: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through SHBP changes. You also may request a copy of this notice at any time.

For More Information about Your Options Under Medicare Prescription Drug Coverage

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

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

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

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

From: January 1, 2026 **To:** December 31, 2026
Date: September 20, 2025

Summaries of Benefits and Coverage

Summaries of benefits and coverage describe each Commercial Plan Option in the standard format required by the Affordable Care Act. These documents are posted here: shbp.georgia.gov. SHBP members can request electronic copies or paper copies of the SBCs on the website at shbp.georgia.gov/sbc-request.

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.

NOTES

Website (mySHBPga.adp.com) for the Annual Retiree Option Change Period is Available October 20, 2025 at midnight ET. through November 7, 2025 at 11:59 p.m. ET For Plan Coverage effective January 1, 2026 – December 31, 2026

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

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