


Benefits Comparison Summary:

SHBP Commercial (active non-MA) Plan Options

A man and a woman are sitting at a table in a modern living room, looking at a laptop. The woman is smiling and pointing at the screen, while the man is looking at the laptop. The room has a wooden wall, a blue sofa, and a potted plant.

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

Benefits Comparison Summary:

HRA Plans | January 1 - 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	\$1,500	\$3,000	\$2,000	\$4,000	\$2,500	\$5,000
• You + Spouse	\$2,250	\$4,500	\$3,000	\$6,000	\$3,750	\$7,500
• You + Child(ren)	\$2,250	\$4,500	\$3,000	\$6,000	\$3,750	\$7,500
• You + Family	\$3,000	\$6,000	\$4,000	\$8,000	\$5,000	\$10,000
	HRA credits will reduce 'You Pay' amounts					
Out-of-Pocket Maximum						
• You	\$4,000	\$8,000	\$5,000	\$10,000	\$6,000	\$12,000
• You + Spouse	\$6,000	\$12,000	\$7,500	\$15,000	\$9,000	\$18,000
• You + Child(ren)	\$6,000	\$12,000	\$7,500	\$15,000	\$9,000	\$18,000
• You + Family	\$8,000	\$16,000	\$10,000	\$20,000	\$12,000	\$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	HRA credits do not apply to HMO and HDHP plans.					
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	\$1,300	\$3,500	\$7,000	\$0
• You + Spouse	\$1,950	\$7,000	\$14,000	\$0
• You + Child(ren)	\$1,950	\$7,000	\$14,000	\$0
• You + Family	\$2,600	\$7,000	\$14,000	\$0
Out-of-Pocket Maximum				
• You	\$4,000	\$6,450	\$12,900	\$6,350
• You + Spouse	\$6,500	\$12,900	\$25,800	\$12,700
• You + Child(ren)	\$6,500	\$12,900	\$25,800	\$12,700
• You + Family	\$9,000	\$12,900	\$25,800	\$12,700
HRA Credits	The Plan Pays	The Plan Pays		The Plan Pays
• You				
• You + Spouse	N/A	N/A		N/A
• You + Child(ren)				
• You + Family				
Physicians' Services	The Plan Pays	The Plan Pays		The Plan Pays
Primary Care Physician or Specialist Office or Clinic Visits • Treatment of illness or injury	100% coverage after \$35 PCP co-pay \$45 SPC co-pay	70% coverage; subject to deductible	50% coverage; subject to deductible	100% coverage after \$35 PCP co-pay \$45 SPC co-pay
Maternity Care (non-routine, prenatal, delivery, and postpartum)	100% coverage after \$35 PCP co-pay \$45 SPC co-pay	70% coverage; subject to deductible	50% coverage; subject to deductible	100% coverage after \$35 PCP co-pay \$45 SPC co-pay
Primary Care Physician or Specialist Office or Clinic Visits for the following: • Wellness care/preventive health care • Prenatal care coded as preventive	100% coverage; not subject to deductible, in-network only	100% coverage; not subject to deductible	Not covered	100% coverage
Physician Services Furnished in a Hospital • Inpatient Visits, including charges by surgeon, anesthesiologist, pathologist and radiologist	100% coverage; subject to deductible	70% coverage; subject to deductible	50% coverage; subject to deductible	100% coverage
Telemedicine/Virtual visit	100% coverage after \$35 PCP co-pay \$45 SPC co-pay	70% coverage; subject to deductible	Not covered	100% coverage

Benefits Comparison Summary:

HRA Plans | January 1 - 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
Physicians' Services	The Plan Pays		The Plan Pays		The Plan Pays	
Physician Services for Emergency Care	85% coverage; subject to deductible		80% coverage; subject to deductible		75% coverage; subject to deductible	
Allergy Shots and Serum	85% coverage; subject to deductible	60% coverage; subject to deductible	80% coverage; subject to deductible	60% coverage; subject to deductible	75% coverage; subject to deductible	60% coverage; subject to deductible
Outpatient Surgery/Services • When billed as an office visit	85% coverage; subject to deductible	60% coverage; subject to deductible	80% coverage; subject to deductible	60% coverage; subject to deductible	75% coverage; subject to deductible	60% coverage; subject to deductible
Outpatient Surgery/Services • When billed with an outpatient surgery at a facility; including charges by surgeon, anesthesiologist, pathologist and radiologist	85% coverage; subject to deductible	60% coverage; subject to deductible	80% coverage; subject to deductible	60% coverage; subject to deductible	75% coverage; subject to deductible	60% coverage; subject to deductible
Hospital Services	The Plan Pays		The Plan Pays		The Plan Pays	
Inpatient Services • Inpatient care, delivery and inpatient short-term acute rehabilitation services	85% coverage; subject to deductible	60% coverage; subject to deductible	80% coverage; subject to deductible	60% coverage; subject to deductible	75% coverage; subject to deductible	60% coverage; subject to deductible
Inpatient Services • Well newborn care	85% coverage; subject to deductible	60% coverage; subject to deductible	80% coverage; subject to deductible	60% coverage; subject to deductible	75% coverage; subject to deductible	60% coverage; subject to deductible
Outpatient Surgery/Services • At a hospital or other facility	85% coverage; subject to deductible	60% coverage; subject to deductible	80% coverage; subject to deductible	60% coverage; subject to deductible	75% coverage; subject to deductible	60% coverage; subject to deductible
Hospital Emergency Room Care • Treatment of an emergency medical condition or injury	85% coverage; subject to in-network deductible		80% coverage; subject to in-network deductible		75% coverage; subject to in-network deductible	
Outpatient Testing, Lab, etc.	The Plan Pays		The Plan Pays		The Plan Pays	
Non-Routine Laboratory; X-Rays; Diagnostic Tests; Injections • Including medications covered under medical benefits for the treatment of an illness or injury NOTE: In-network diagnostic colonoscopies and mammograms/diagnostic breast services 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
Physicians' Services	The Plan Pays	The Plan Pays		The Plan Pays
Physician Services for Emergency Care	100% coverage	70% coverage; subject to in-network deductible		100% coverage
Allergy Shots and Serum • Co-pay only applies when billed with an office visit	100% after \$35 PCP co-pay \$45 SPC co-pay	70% coverage; subject to deductible	50% coverage; subject to deductible	100% after \$35 PCP co-pay \$45 SPC co-pay
Outpatient Surgery/Services • When billed as an office visit	100% after \$35 PCP co-pay \$45 SPC co-pay	70% coverage; subject to deductible	50% coverage; subject to deductible	100% after \$35 PCP co-pay \$45 SPC co-pay
Outpatient Surgery/Services • When billed with an outpatient surgery at a facility, including charges by surgeon, anesthesiologist, pathologist and radiologist	80% coverage; subject to deductible	70% coverage; subject to deductible	50% coverage; subject to deductible	100% coverage after \$100 co-pay
Hospital Services	The Plan Pays	The Plan Pays		The Plan Pays
Inpatient Services • Inpatient care, delivery and inpatient short-term acute rehabilitation services	80% coverage; subject to deductible	70% coverage; subject to deductible	50% coverage; subject to deductible	100% coverage after \$250 co-pay
Inpatient Services • Well newborn care	100% coverage	70% coverage; subject to deductible	50% coverage; subject to deductible	100% coverage
Outpatient Surgery/Services • At a hospital or other facility	80% coverage; subject to deductible	70% coverage; subject to deductible	50% coverage; subject to deductible	100% coverage after \$100 co-pay
Hospital Emergency Room Care • Treatment of an emergency medical condition or injury	100% coverage after \$200 co-pay, co-pay waived if admitted	70% coverage; subject to in-network deductible		100% coverage after \$200 co-pay, co-pay waived if admitted
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 freestanding 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. • Dilated retinal eye exam is covered at 100% once per calendar year.	100% coverage; not subject to deductible Out-of-network eye exam not covered		100% coverage; not subject to deductible Out-of-network eye exam not covered		100% coverage; not subject to deductible Out-of-network eye exam not covered	
Hearing Services Routine Hearing Exam when properly coded as preventive	100% coverage	Not covered	100% coverage	Not covered	100% coverage	Not covered
Hearing Services Non-routine hearing not performed in an office setting	85% coverage; subject to deductible	60% coverage; subject to deductible	80% coverage; subject to deductible	60% coverage; subject to deductible	75% coverage; subject to deductible	60% coverage; subject to deductible
Hearing Aid: Adult Fittings	85% coverage for exam and fittings (subject to deductible); \$1,500 hearing aid allowance every five years (not subject to deductible)		80% coverage for exam and fittings (subject to deductible); \$1,500 hearing aid allowance every five years (not subject to deductible)		75% coverage for exam and fittings (subject to deductible); \$1,500 hearing aid allowance every five years (not subject to deductible)	
Hearing Aid: Children (Up to age 19) Fittings	85% coverage for exam and fittings (subject to deductible); \$3,000 hearing aid allowance per hearing impaired ear every four years (not subject to deductible)		80% coverage for exam and fittings (subject to deductible); \$3,000 hearing aid allowance per hearing impaired ear every four years (not subject to deductible)		75% coverage for exam and fittings (subject to deductible); \$3,000 hearing aid allowance per hearing impaired ear every four years (not subject to deductible)	

Benefits Comparison Summary:

HMO and HDHP Plans | January 1 - 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/family 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 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)	70% coverage for exam and fittings (subject to deductible); \$1,500 hearing aid allowance every five years (subject to deductible)		100% coverage for exam and fittings; \$1,500 hearing aid allowance every five years
Hearing Aid: Children (Up to age 19) Fittings	100% for exam and fittings; after \$35 PCP co-pay \$45 SPC co-pay \$3,000 hearing aid allowance per hearing impaired ear every four years (not subject to deductible)	70% coverage for exam and fittings (subject to deductible); \$3,000 hearing aid allowance per hearing impaired ear every four years (subject to deductible)		100% coverage for exam and fittings; \$3,000 hearing aid allowance per hearing impaired ear every four years (not subject to deductible)

Benefits Comparison Summary:

HRA Plans | January 1 - 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 office place of service. 100% coverage for all other places of service	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% coverage up to 120 days per Plan Year	70% coverage; up to 120 days per Plan Year; subject to deductible	Not Covered	100% coverage up to 120 days per Plan Year
Hospice Care NOTE: Prior approval required.	100% coverage	70% coverage; subject to deductible	50% coverage; subject to deductible	100% coverage
Durable Medical Equipment (DME) - Rental or purchase NOTE: Prior approval required for certain DME.	100% coverage	70% coverage; subject to deductible	50% coverage; subject to deductible	100% coverage
Transplant Services NOTE: Prior approval required.	Contact the Medical Claim Administrator for coverage details.			

Benefits Comparison Summary:

HRA Plans | January 1 - 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).

Additional information

- Amounts you pay go toward the out-of-pocket maximum.
 - If you or your physician request a Brand-name Prescription Drug Product in place of the chemically equivalent Prescription Drug Product (Generic equivalent), you will pay the applicable Brand co-insurance in addition to the difference between the Brand and Generic Drug costs. This differential will apply toward your out-of-pocket maximum.
 - CVS Caremark® administers the pharmacy benefits for members enrolled in Anthem HRA Plan Options.
- **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-Net- work	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).

Additional information

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

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