2025 - 2026 Benefit to Benefit Grid

Effective on your group's renewal on or after January 1, 2026

Amended Plans - EMPLOYEEELECT and SHOP MIRROR PORTFOLIO

Below is an overview of changes and updates made to your medical plan which will take effect with your plan's renewal. **For a complete listing of all your benefits, limitations and exclusions, please review the complete Evidence of Coverage (EOC)**.
Amounts listed below are the member's responsibility to pay after any applicable In-Network (INN) or Out-of-Network (OON) deductibles (unless otherwise specified).

ALL PLANS - GENERAL MANDATES UPDATE			
		Description:	**Impact:**
AB 1936 (Cervantes, Ch. 815, Stats. 2024) - Maternal Mental Health Screenings	All:	Requires the plan's maternal mental health program to consist of at least one maternal mental health screening during pregnancy, at least one additional screening during the first 6 weeks of the postpartum period, and additional postpartum screenings, if determined medically necessary and clinically appropriate in the judgment of the treating provider.	***Anthem Blue Cross to comply with these new requirements for plans and policies that are issued or renewed on or after January 1, 2025.***
AB 3059 (Weber, Ch. 975, Stats. 2024) - Human Milk	All:	Health care service plans and health insurers must cover the provision of medically necessary pasteurized donor human milk obtained from a tissue licensed bank as a basic health care service.	***Anthem Blue Cross to comply with these new requirements for plans and policies that are issued or renewed on or after January 1, 2025.***
AB 2843 (Petrie-Norris, Ch. 971, Stats. 2024) - Health Care Coverage: Rape and Sexual Assault	All:	Requires health plan and insurance coverage without cost-sharing for emergency room medical care and follow-up treatment for rape or sexual assault for the first 9 months after the enrollee initiates treatment, as specified.	***Anthem Blue Cross to comply with these new requirements for plans and policies that are issued or renewed on or after July 1, 2025.***
SB 729 (Menjivar, Ch. 930, Stats. 2024) - Health Care Coverage: Treatment for Infertility and Fertility Services	All:	Requires large group plans to cover diagnosis and treatment of infertility; requires small group plans only to offer. Individual plans are not subject to the bill. By extension, student plans also might not be subject to the bill.	***Anthem Blue Cross to comply with these new requirements for plans and policies that are issued or renewed on or after January 1, 2026.***
ALL PLANS - GENERAL UPDATE		**Current 2025 plan**	***New 2026 plan***
Doula Services		Doula services include personal emotional and physical support to women and families from pregnancy experience through childbirth and postpartum. Doulas have been shown to prevent perinatal complications, improve birth outcomes, and reduce health disparities.	***If you are pregnant or were pregnant within the last twelve (12) months. Prenatal, labor and delivery, and postpartum services provided by a doula include the following:*** ***•One initial visit,*** ***•Up to eight one-hour visits that may be provided in any combination of prenatal and postpartum visits,*** ***•Support during labor and delivery and during/after miscarriage***

PPO Plan Updates	Network:	Current 2025 plan	*New 2026 plan*
PLAN NAME (S):		Anthem Gold PPO 25/30% Anthem Gold Select PPO 25/30%	Anthem Gold PPO 25/30% Anthem Gold Select PPO 25/30%
OUT-OF-POCKET MAXIMUM (Individual/Family)			
In-network Out of Pocket	INN:	$8,700/$17,400	***$10,150/$20,300***
Out-of-network Out of Pocket	OON:	$17,400/$34,800	***$20,300/$40,600***
PLAN NAME (S):		Anthem Silver PPO 55/1950/35% Anthem Silver Select PPO 55/1950/35%	Anthem Silver PPO 55/1950/35% Anthem Silver Select PPO 55/1950/35%
OUT-OF-POCKET MAXIMUM (Individual/Family)			
In-network Out of Pocket	INN:	$9,100/$18,200	***$10,150/$20,300***
Out-of-network Out of Pocket	OON:	$18,200/$36,400	***$20,300/$40,600***
PLAN NAME (S):		Anthem Bronze PPO 75/7300/40% Anthem Bronze Select PPO 75/7300/40%	Anthem Bronze PPO 75/7300/40% Anthem Bronze Select PPO 75/7300/40%
OUT-OF-POCKET MAXIMUM (Individual/Family)			
In-network Out of Pocket	INN:	$9,100/$18,200	***$10,150/$20,300***
Out-of-network Out of Pocket	OON:	$18,200/$36,400	***$20,300/$40,600***

HSA Plans	Network:	Current 2025 plan	New 2026 plan
PLAN NAME (S):		Anthem Gold PPO HSA/H 1700/3300/3400 15% PrevRx* Anthem Gold Select PPO HSA/H 1700/3300 /3400 15% PrevRx*	***Anthem Gold PPO HSA/H 1900/3400/3800 15% PrevRx**** ***Anthem Gold Select PPO HSA/H 1900/3400/ 3800 15% PrevRx****
DEDUCTIBLE			
In-network	INN:	Subscriber only contract, Per Member Deductible: $1,700 Subscriber + Family contract, Per Member Deductible: $3,300 Subscriber + Family contract, Family Deductible: $3,400	***Subscriber only contract, Per Member Deductible: $1,900*** ***Subscriber + Family contract, Per Member Deductible: $3,400*** ***Subscriber + Family contract, Family Deductible: $3,800***
Out-of-network	OON:	Subscriber only contract, Per Member Deductible: $3,400 Subscriber + Family contract, Per Member Deductible: $6,600 Subscriber + Family contract, Family Deductible: $6,800	***Subscriber only contract, Per Member Deductible: $3,800*** ***Subscriber + Family contract, Per Member Deductible: $6,800*** ***Subscriber + Family contract, Family Deductible: $7,600***
OUT-OF-POCKET MAXIMUM			
In-network Out of Pocket	INN:	Per Member: $3,900/ Per Family: $7,800	***Per Member: $4,500/ Per Family: $9,000***
Out-of-network Out of Pocket	OON:	Per Member: $7,800/ Per Family: $15,600	***Per Member: $9,000/ Per Family: $18,000***

PLAN NAME (S):		Anthem Silver PPO HSA/H 2100/3300/4200 30% PrevRx* Anthem Silver Select PPO HSA/H 2100/3300/ 4200 30% PrevRx*	***Anthem Silver PPO HSA/H 2300/3400/4600 30% PrevRx**** ***Anthem Silver Select PPO HSA/H 2300/ 3400/4600 30% PrevRx****
DEDUCTIBLE			
In-network	INN:	Subscriber only contract, Per Member Deductible: $2,100 Subscriber + Family contract, Per Member Deductible: $3,300 Subscriber + Family contract, Family Deductible: $4,200	***Subscriber only contract, Per Member Deductible: $2,300*** ***Subscriber + Family contract, Per Member Deductible: $3,400*** ***Subscriber + Family contract, Family Deductible: $4,600***
Out-of-network	OON:	Subscriber only contract, Per Member Deductible: $4,200 Subscriber + Family contract, Per Member Deductible: $6,600 Subscriber + Family contract, Family Deductible: $8,400	***Subscriber only contract, Per Member Deductible: $4,600*** ***Subscriber + Family contract, Per Member Deductible: $6,800*** ***Subscriber + Family contract, Family Deductible: $9,200***
OUT-OF-POCKET MAXIMUM			
In-network Out of Pocket	INN:	Per Member: $7,750/ Per Family: $15,500	***Per Member: $8,450/ Per Family: $16,900***
Out-of-network Out of Pocket	OON:	Per Member: $15,500/ Per Family: $31,000	***Per Member: $16,900/ Per Family: $33,800***
PLAN NAME (S):		Anthem Silver PPO HSA/H 2600/3300/5200 35% PrevRx* Anthem Silver Select PPO HSA/H 2600/3300/5200 35% PrevRx*	Anthem Silver PPO HSA/H 2600/***3400*** /5200 35% PrevRx* Anthem Silver Select PPO HSA/H 2600/***3400*** / 5200 35% PrevRx*
DEDUCTIBLE			
In-network	INN:	Subscriber only contract, Per Member Deductible: $2,600 Subscriber + Family contract, Per Member Deductible: $3,300 Subscriber + Family contract, Family Deductible: $5,200	Subscriber only contract, Per Member Deductible: $2,600 Subscriber + Family contract, Per Member Deductible: ***$3,400*** Subscriber + Family contract, Family Deductible: $5,200
Out-of-network	OON:	Subscriber only contract, Per Member Deductible: $5,200 Subscriber + Family contract, Per Member Deductible: $6,600 Subscriber + Family contract, Family Deductible: $10,400	Subscriber only contract, Per Member Deductible: $5,200 Subscriber + Family contract, Per Member Deductible: **$6,800** Subscriber + Family contract, Family Deductible: $10,400
OUT-OF-POCKET MAXIMUM			
In-network Out of Pocket	INN:	Per Member: $7,050/ Per Family: $14,100	***Per Member: $8,450/ Per Family: $16,900***
Out-of-network Out of Pocket	OON:	Per Member: $14,100/ Per Family: $28,200	***Per Member: $16,900/ Per Family: $33,800***
PLAN NAME (S):		Anthem Bronze Select PPO 6650/0% w/HSA	***Anthem Bronze Select PPO 7200/0% w/HSA***
DEDUCTIBLE (Individual/Family)			
In-network	INN:	$6,650/$13,300	***$7,200/$14,400***
Out-of-network	OON:	$13,300/$26,600	***$14,400/$28,800***
OUT-OF-POCKET MAXIMUM (Individual/Family)			
In-network Out of Pocket	INN:	$6,650/$13,300	***$7,200/$14,400***
Out-of-network Out of Pocket	OON:	$16,625/$33,250	***$18,000/$36,000***

HMO Plans*	Network:	Current 2025 plan	New 2026 plan
PLAN NAME (S):		Anthem Platinum Priority Select HMO 0/20 Anthem Platinum Priority Select HMO 0/25 Anthem Platinum Priority Select HMO 0/30 Anthem Gold Priority Select HMO 30 Anthem Gold Priority Select HMO 35 Anthem Gold Priority Select HMO 35/500/20% Anthem Gold Priority Select HMO 35/1250/20%	***Anthem Platinum Priority Select HMO 20*** ***Anthem Platinum Priority Select HMO 25*** ***Anthem Platinum Priority Select HMO 30*** Anthem Gold Priority Select HMO 30 Anthem Gold Priority Select HMO 35 Anthem Gold Priority Select HMO 35/500/20% Anthem Gold Priority Select HMO 35/1250/20%
GENERAL UPDATE			
Network name change	INN:	Priority Select HMO	***Small Group Priority Select HMO***
PLAN NAME (S):		Anthem Platinum HMO 0/20 Anthem Platinum Select HMO 0/20 Anthem Platinum Priority Select HMO 0/20	***Anthem Platinum HMO 20*** ***Anthem Platinum Select HMO 20*** ***Anthem Platinum Priority Select HMO 20***
OUT-OF-POCKET MAXIMUM			
In-network Out of Pocket	INN:	Per Member: $1,900/ Per Family: $3,800	***Per Member: $2,100/ Per Family: $4,200***
MEDICAL BENEFITS			
Emergency Room Copay	INN:	$250 copay	***$300 copay***
Outpatient Hospital Facility: Manipulative Treatment	INN:	$20 copay	***$15 copay***
PLAN NAME (S):		Anthem Platinum HMO 0/25 Anthem Platinum Select HMO 0/25 Anthem Platinum Priority Select HMO 0/25	***Anthem Platinum HMO 25*** ***Anthem Platinum Select HMO 25*** ***Anthem Platinum Priority Select HMO 25***
MEDICAL BENEFITS			
Outpatient Hospital Facility: Manipulative Treatment	INN:	$25 copay	***$15 copay***
PLAN NAME (S):		Anthem Platinum HMO 0/30 Anthem Platinum Select HMO 0/30 Anthem Platinum Priority Select HMO 0/30	***Anthem Platinum HMO 30*** ***Anthem Platinum Select HMO 30*** ***Anthem Platinum Priority Select HMO 30***
MEDICAL BENEFITS			
Outpatient Hospital Facility: Manipulative Treatment	INN:	$30 copay	***$15 copay***
PLAN NAME (S):		Anthem Gold HMO 30 Anthem Gold Select HMO 30 Anthem Gold Priority Select HMO 30	Anthem Gold HMO 30 Anthem Gold Select HMO 30 Anthem Gold Priority Select HMO 30
MEDICAL BENEFITS			
Outpatient Hospital Facility: Manipulative Treatment	INN:	$30 copay	***$15 copay***
PLAN NAME (S):		Anthem Gold HMO 35 Anthem Gold Select HMO 35 Anthem Gold Priority Select HMO 35	Anthem Gold HMO 35 Anthem Gold Select HMO 35 Anthem Gold Priority Select HMO 35
MEDICAL BENEFITS			
Outpatient Hospital Facility: Manipulative Treatment	INN:	$35 copay	***$15 copay***
PLAN NAME (S):		Anthem Gold HMO 35/500/20% Anthem Gold Select HMO 35/500/20% Anthem Gold Priority Select HMO 35/500/20%	Anthem Gold HMO 35/500/20% Anthem Gold Select HMO 35/500/20% Anthem Gold Priority Select HMO 35/500/20%

MEDICAL BENEFITS			
Outpatient Hospital Facility: Manipulative Treatment	INN:	Deductible, then 20% coinsurance	***$15 copay, deductible waived***
PLAN NAME (S):		Anthem Gold HMO 35/1250/20% Anthem Gold Select HMO 35/1250/20% Anthem Gold Priority Select HMO 35/1250/20%	Anthem Gold HMO 35/1250/20% Anthem Gold Select HMO 35/1250/20% Anthem Gold Priority Select HMO 35/1250/ 20%
MEDICAL BENEFITS			
Outpatient Hospital Facility: Manipulative Treatment	INN:	Deductible, then 20% coinsurance	***$15 copay, deductible waived***
PLAN NAME (S):		Anthem Silver HMO 55 Anthem Silver Select HMO 55	Anthem Silver HMO 55 Anthem Silver Select HMO 55
MEDICAL BENEFITS			
Outpatient Hospital Facility: Manipulative Treatment	INN:	$35 copay	***$15 copay***
PLAN NAME (S):		Anthem Silver HMO 60/2500/45% Anthem Silver Select HMO 60/2500/45% Anthem Silver Select HMO 60/2500/45% WH	Anthem Silver HMO 60/2500/45% Anthem Silver Select HMO 60/2500/45% Anthem Silver Select HMO 60/2500/45% WH
OUT-OF-POCKET MAXIMUM			
In-network Out of Pocket	INN:	Per Member: $9,100/ Per Family: $18,200	***Per Member: $10,150/ Per Family: $20,300***
MEDICAL BENEFITS			
Emergency Room Copay	INN:	$350 copay	***$500 copay***
Outpatient Hospital Facility: Manipulative Treatment	INN:	Deductible, then 45% coinsurance	***$15 copay, deductible waived***
PLAN NAME (S):		Anthem Platinum Vivity HMO 15 Anthem Platinum Vivity HMO 15 WH	Anthem Platinum Vivity HMO 15 Anthem Platinum Vivity HMO 15 WH
MEDICAL BENEFITS			
Outpatient Hospital Facility: Manipulative Treatment	INN:	$25 copay	***$15 copay***
PLAN NAME (S):		Anthem Gold Vivity HMO 25 Anthem Gold Vivity HMO 25 WH	Anthem Gold Vivity HMO 25 Anthem Gold Vivity HMO 25 WH
OUT-OF-POCKET MAXIMUM			
In-network Out of Pocket	INN:	Per Member: $7,000/ Per Family: $14,000	***Per Member: $8,00/ Per Family: $16,000***
MEDICAL BENEFITS			
Outpatient Hospital Facility: Manipulative Treatment	INN:	$25 copay	***$15 copay***
Wigs	INN:	$150 copay	***$100 copay***
PLAN NAME (S):		Anthem Gold Vivity HMO 25/500 Anthem Gold Vivity HMO 25/500 WH	Anthem Gold Vivity HMO 25/500 Anthem Gold Vivity HMO 25/500 WH
MEDICAL BENEFITS			
Outpatient Hospital Facility: Manipulative Treatment	INN:	$30 copay	***$15 copay***
Wigs	INN:	$150 copay	***$100 copay***
PLAN NAME (S):		Anthem Gold Vivity HMO 35/1000 Anthem Gold Vivity HMO 35/1000 WH	Anthem Gold Vivity HMO 35/1000 Anthem Gold Vivity HMO 35/1000 WH
MEDICAL BENEFITS			

Outpatient Hospital Facility: Manipulative Treatment	INN:	$30 copay	***$15 copay***
Wigs	INN:	$150 copay	***$100 copay***
PLAN NAME (S):		Anthem Gold Vivity HMO 35/1850 Anthem Gold Vivity HMO 35/1850 WH	Anthem Gold Vivity HMO 35/1850 Anthem Gold Vivity HMO 35/1850 WH
MEDICAL BENEFITS			
Outpatient Hospital Facility: Manipulative Treatment	INN:	$30 copay	***$15 copay***
Wigs	INN:	$150 copay	***$100 copay***

* These plans have a different per-member deductible amount, depending on whether the subscriber is enrolled as self-only, or has enrolled dependents within the plan. Plans have been designed in this manner to comply with both AB1305 and IRS minimum deductible and out-of-pocket maximum requirements for embedded high- deductible health plans.

**Enrollment in the selected plan is dependent upon the employee residing or working within a plan's geographical service area, and the network, provider, and physician availability within the geographical service area. If at the time of enrollment, the network or physician/medical group is not available or an employee does not reside or work in the geographical service area of the plan, the employee may be assigned to or be required to choose a different provider, network, and/or plan.

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