California

Effective January 1, 2026

Anthem

Medical

Benefit charts

2026 Small Group ACA plans

ALL PRODUCT OFFERINGS ARE SUBJECT TO REGULATORY REVIEW AND APPROVAL

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WE'RE HELPING SOLVE TODAY'S TOUGHEST HEALTHCARE CHALLENGES

By connecting individuals to the care, support, and resources they need to thrive, we're going beyond traditional health insurance to focus on a bigger whole-health picture.

We're here to support you with:



A transformative digital-first experience. Using innovative digital solutions, advanced analytics, and apps like Sydney℠ Health, we're simplifying and personalizing healthcare delivery.



Meaningful connections through whole-person care. Through medical, pharmacy, and specialty integration, we're leaning into whole-health programs like Wellbeing Solutions to improve outcomes and lower costs.



Collaborative expertise with our network advantage. By leveraging our partnerships, networks, and strong provider relationships, we're supporting access to high-quality, equitable care.

As your trusted partner, we're here to promote an effective healthcare strategy that reinforces innovation, integration, and collaboration.

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Sydney Health is offered through an arrangement with Carelon Digital Platforms, a separate company offering mobile application services on behalf of Anthem Blue Cross health plans ©2023.

Small Group EmployeeElect product details – groups of 1 to 100 employees

***NEW* for 2026 Virtual Access Plus PPO Plans**

- Available with the Prudent Buyer and Select PPO networks
- Virtual Access Plus includes features of Alternative Health Plans, such as a copay design and free virtual primary care visits, along with a refined digital experience and strong member support. These elements are designed to empower members to manage their healthcare costs effectively.

Our networks:

- Vivity — our integrated health system network in Los Angeles and Orange counties
- CaliforniaCare HMO — our most comprehensive statewide HMO network
- Select HMO — our high-performance narrow HMO network available in certain counties
- Small Goup Priority Select HMO — our most efficient network in select counties
- Prudent Buyer PPO — our most comprehensive statewide PPO network
- Select PPO — our high-performance narrow PPO network

The following benefit charts show in-network benefits. Our PPO plans include out-of-network benefits. For more plan information, please refer to the Summary of Benefits (SOB). To find a specific SOB for any of these plans, visit **https://plan-summaries.anthem.com/sobdps/**.

All product offerings are subject to regulatory review and approval and are subject to change. Plans offered by Anthem Blue Cross.

Small Group EmployeeElect product details – groups of 1 to 100 employees

Anthem PPO plans

	Platinum plans	Gold plans	
Plan name	**Anthem Virtual Access Plus Platinum PPO 20 Ω *NEW***	**Anthem Virtual Access Plus Gold PPO 30 Ω *NEW***	**Anthem Virtual Access Plus Gold PPO 10/1500 Ω *NEW***
Network (contract codes)	Prudent Buyer PPO (8VEN) Select PPO (8VEU)	Prudent Buyer PPO (8VEL) Select PPO (8VER)	Prudent Buyer PPO (8VEP) Select PPO (8VET)
In-network deductible (individual/family)	$0/$0	$0/$0	$1,500/$4,500
Out-of-network deductible (individual/family)	$2,000/$4,000	$2,000/$4,000	$3,000/$6,000
In-network coinsurance	None	None	None
Out-of-network coinsurance	50%	50%	50%
In-network out-of-pocket maximum (individual/family)	$2,750/$5,500	$9,000/$18,000	$7,000/$14,000
Out-of-network out-of-pocket maximum (individual/family)	$5,500/$11,000	$18,000/$36,000	$14,000/$28,000
Office and virtual visits[1]: Primary care (PCP)/Specialist (SPC)	PCP: $20 SPC: $40	PCP: $30 SPC: $60	PCP: $10 SPC: $60
Virtual primary care and urgent/acute care services: Virtual care-only provider[2]	Covered in full	Covered in full	Covered in full
Urgent care (office)	$20	$30	$10
Emergency room (facility)	$250	$500	Deductible, then $500
Independent facility: ambulatory outpatient surgery center	$75	$250	$250
Hospital outpatient surgery facility	$150	$250	Deductible, then $100
Hospital inpatient admission	$250 per day up to 4 days per admission	$500 per day up to 4 days per admission	Deductible, then $500 per admission
Prescription drugs: network/drug list	Rx Choice Tiered Network with R90/ Select	Rx Choice Tiered Network with R90/ Select	Rx Choice Tiered Network with R90/ Select
Pharmacy deductible[3] (individual/family)	Tiers 1-4: No deductible	Tiers 1-4: No deductible	Tiers 1-3: No deductible Tier 4: Medical deductible applies
Retail pharmacy: 30-day supply (tier 1/tier 2/tier 3/tier 4)	Level 1: $5/$25/$75/$250 Level 2: $15/$35/$85/$250	Level 1: $5/$25/$75/$250 Level 2: $15/$35/$85/$250	Level 1: $10/$40/$100/$250 Level 2: $20/$50/$110/$250
Home delivery pharmacy[4] (tier 1/tier 2/tier 3/tier 4)	$10/$63/$188/$250	$10/$63/$188/$250	$20/$100/$250/$250
Dental and vision	Pediatric dental and vision covered Adult dental not covered, eye exam only covered	Pediatric dental and vision covered Adult dental not covered, eye exam only covered	Pediatric dental and vision covered Adult dental not covered, eye exam only covered

Footnotes

Ω Site of Service plan may have reduced cost shares for laboratory services received at an independent lab; radiology and advanced diagnostic imaging services received at an independent radiology center; and outpatient surgery received at an ambulatory surgical center.Ω

◊ These plans have a different deductible amount if the subscriber is enrolled as self only or has enrolled dependents in the plan (Subscriber only/Subscriber enrolled with a Family/Family). Plans comply with AB1305 and IRS minimum deductible and out-of-pocket maximum requirements for embedded high-deductible health plans.

† After deductible has been met on this plan, medical benefits are paid at 100% and pharmacy benefits apply member copays as listed.

‡ Deductible waived for drugs on the PreventiveRx Plus drug list.

1 Primary care physician (PCP) and Specialist (SPC) cost share applies to medical office visits and virtual visits with a member's regular PCP or SPC. NOTE: The PCP cost share does not apply to virtual primary care visits for **Virtual Access Plus** and **Vivity HMO plans** which are covered in full.

2 Cost share may apply to virtual visits for urgent/acute medical and behavioral health (mental health/substance use disorder) services from the virtual care only providers available through Sydney Health and our website. In addition, virtual visits for Building Healthy Families Breastfeeding Support and EAP counseling visits from our virtual care-only providers are included with all medical plans at no additional cost.

3 For plans with a deductible, the pharmacy cost share applies after deductible for the tiers as listed. For plans with a separate pharmacy deductible, the deductible is combined for retail and home delivery.

4 Home delivery program typically covers up to a 90-day supply for tier 1, tier 2 and tier 3 drugs and up to a 30-day supply for tier 4 drugs.

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Small Group EmployeeElect product details – groups of 1 to 100 employees

Anthem PPO plans

	Gold plans	Silver plans
Plan name	**Anthem Virtual Access Plus Gold PPO 25/1000 Ω *NEW***	**Anthem Virtual Access Plus Silver PPO 50/3200 Ω *NEW***
Network (contract codes)	Prudent Buyer PPO (8VEK) Select PPO (8VEV)	Prudent Buyer PPO (8VEQ) Select PPO (8VEW)
In-network deductible (individual/family)	$1,000/$3,000	$3,200/$6,400
Out-of-network deductible (individual/family)	$2,000/$4,000	$6,400/$12,800
In-network coinsurance	None	None
Out-of-network coinsurance	50%	50%
In-network out-of-pocket maximum (individual/family)	$5,000/$10,000	$10,150/$20,300
Out-of-network out-of-pocket maximum (individual/family)	$10,000/$20,000	$20,300/$40,600
Office and virtual visits[1]: Primary care (PCP)/Specialist (SPC)	PCP: $25 SPC: $50	PCP: $50 SPC: $90
Virtual primary care and urgent/acute care services: Virtual care-only provider[2]	Covered in full	Covered in full
Urgent care (office)	$25	$50
Emergency room (facility)	Deductible, then $350	Deductible, then $500
Independent facility: ambulatory outpatient surgery center	$250	$250
Hospital outpatient surgery facility	Deductible, then $250	Deductible, then $350
Hospital inpatient admission	Deductible, then $500 per admission	Deductible, then $1,000 per admission
Prescription drugs: network/drug list	Rx Choice Tiered Network with R90/ Select	Rx Choice Tiered Network with R90/ Select
Pharmacy deductible[3] (individual/family)	Tiers 1-3: No deductible Tier 4: Medical deductible applies	Tiers 1-3: No deductible Tier 4: Medical deductible applies
Retail pharmacy: 30-day supply (tier 1/tier 2/tier 3/tier 4)	Level 1: $10/$40/$100/$250 Level 2: $20/$50/$110/$250	Level 1: $10/$40/$100/$250 Level 2: $20/$50/$110/$250
Home delivery pharmacy[4] (tier 1/tier 2/tier 3/tier 4)	$20/$100/$250/$250	$20/$100/$250/$250
Dental and vision	Pediatric dental and vision covered Adult dental not covered, eye exam only covered	Pediatric dental and vision covered Adult dental not covered, eye exam only covered

Footnotes

Ω Site of Service plan may have reduced cost shares for laboratory services received at an independent lab; radiology and advanced diagnostic imaging services received at an independent radiology center; and outpatient surgery received at an ambulatory surgical center.Ω

◊ These plans have a different deductible amount if the subscriber is enrolled as self only or has enrolled dependents in the plan (Subscriber only/Subscriber enrolled with a Family/Family). Plans comply with AB1305 and IRS minimum deductible and out-of-pocket maximum requirements for embedded high-deductible health plans.

† After deductible has been met on this plan, medical benefits are paid at 100% and pharmacy benefits apply member copays as listed.

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4 Home delivery program typically covers up to a 90-day supply for tier 1, tier 2 and tier 3 drugs and up to a 30-day supply for tier 4 drugs.

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Small Group EmployeeElect product details – groups of 1 to 100 employees

Anthem PPO plans

	Platinum plans		
Plan name	**Anthem Platinum Select PPO 15/10%**	**Anthem Platinum PPO 15/40/10% Ω**	**Anthem Platinum PPO 5/200/15% Ω**
Network (contract codes)	Select PPO (8ZWZ)	Prudent Buyer PPO (94HX) Select PPO (94HV)	Prudent Buyer PPO (8V64) Select PPO (8V63)
In-network deductible (individual/family)	$0/$0	$0/$0	$200/$600
Out-of-network deductible (individual/family)	$2,000/$4,000	$2,000/$4,000	$2,000/$4,000
In-network coinsurance	10%	10%	15%
Out-of-network coinsurance	50%	50%	50%
In-network out-of-pocket maximum (individual/family)	$4,500/$9,000	$3,800/$7,600	$3,600/$7,200
Out-of-network out-of-pocket maximum (individual/family)	$9,000/$18,000	$7,600/$15,200	$7,200/$14,400
Office and virtual visits[1]: Primary care (PCP)/Specialist (SPC)	PCP: $15 SPC: $30	PCP: $15 SPC: $40	PCP: $5 SPC: $45
Virtual primary care and urgent/acute care services: Virtual care-only provider[2]	Covered in full	Covered in full	Covered in full
Urgent care (office)	$15	$15	$5
Emergency room (facility)	$200	$200, then 10% coinsurance	Deductible, then $250 and 15% coinsurance
Independent facility: ambulatory outpatient surgery center	10% coinsurance	$50, then 10% coinsurance	Deductible, then $50 and 15% coinsurance
Hospital outpatient surgery facility	10% coinsurance	$200, then 10% coinsurance	Deductible, then $250 and 15% coinsurance
Hospital inpatient admission	10% coinsurance	10% coinsurance	Deductible, then 15% coinsurance
Prescription drugs: network/drug list	Advantage with R90/Select	Rx Choice Tiered Network with R90/Select	Rx Choice Tiered Network with R90/Select
Pharmacy deductible[3] (individual/family)	Tiers 1-4: No deductible	Tiers 1-4: No deductible	Tiers 1-4: No deductible
Retail pharmacy: 30-day supply (tier 1/tier 2/tier 3/tier 4)	$10/$25/$40/10% up to $250 per script	Level 1: $5/$30/$50/30% up to $250 per script Level 2: $15/$40/$60/40% up to $250 per script	Level 1: $5/$30/$50/30% up to $250 per script Level 2: $15/$40/$60/40% up to $250 per script
Home delivery pharmacy[4] (tier 1/tier 2/tier 3/tier 4)	$20/$63/$100/10% up to $250 per script	$10/$75/$125/30% up to $250 per script	$10/$75/$125/30% up to $250 per script
Dental and vision	Pediatric dental and vision covered Adult dental not covered, eye exam only covered	Pediatric dental and vision covered Adult dental not covered, eye exam only covered	Pediatric dental and vision covered Adult dental not covered, eye exam only covered

Footnotes

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◊ These plans have a different deductible amount if the subscriber is enrolled as self only or has enrolled dependents in the plan (Subscriber only/Subscriber enrolled with a Family/Family). Plans comply with AB1305 and IRS minimum deductible and out-of-pocket maximum requirements for embedded high-deductible health plans.

† After deductible has been met on this plan, medical benefits are paid at 100% and pharmacy benefits apply member copays as listed.

‡ Deductible waived for drugs on the PreventiveRx Plus drug list.

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Small Group EmployeeElect product details – groups of 1 to 100 employees

Anthem PPO plans

	Platinum plans	Gold plans	
Plan name	**Anthem Platinum PPO 15/250/10% Ω**	**Anthem Gold PPO 25/30% Ω**	**Anthem Gold Select PPO 25/350/20%**
Network (contract codes)	Prudent Buyer PPO (8V6N) Select PPO (8V6M)	Prudent Buyer PPO (94J8) Select PPO (94J9)	Select PPO (8ZX4)
In-network deductible (individual/family)	$250/$750	$0/$0	$350/$700
Out-of-network deductible (individual/family)	$2,000/$4,000	$2,000/$4,000	$2,000/$4,000
In-network coinsurance	10%	30%	20%
Out-of-network coinsurance	50%	50%	50%
In-network out-of-pocket maximum (individual/family)	$3,700/$7,400	$10,150/$20,300	$7,800/$15,600
Out-of-network out-of-pocket maximum (individual/family)	$7,400/$14,800	$20,300/$40,600	$15,600/$31,200
Office and virtual visits[1]: Primary care (PCP)/Specialist (SPC)	PCP: $15 SPC: $30	PCP: $25 SPC: $50	PCP: $25 SPC: $50
Virtual primary care and urgent/acute care services: Virtual care-only provider[2]	Covered in full	Covered in full	Covered in full
Urgent care (office)	$15	$25	$25
Emergency room (facility)	Deductible, then $225 and 10% coinsurance	$400, then 30% coinsurance	Deductible, then 20% coinsurance
Independent facility: ambulatory outpatient surgery center	Deductible, then $50 and 10% coinsurance	$50, then 30% coinsurance	20% coinsurance
Hospital outpatient surgery facility	Deductible, then $250 and 10% coinsurance	$250, then 30% coinsurance	20% coinsurance
Hospital inpatient admission	Deductible, then 10% coinsurance	30% coinsurance	Deductible, then 20% coinsurance
Prescription drugs: network/drug list	Rx Choice Tiered Network with R90/ Select	Rx Choice Tiered Network with R90/ Select	Advantage with R90/Select
Pharmacy deductible[3] (individual/family)	Tiers 1-4: No deductible	Tiers 1-4: No deductible	Tiers 1-4: No deductible
Retail pharmacy: 30-day supply (tier 1/tier 2/tier 3/tier 4)	Level 1: $5/$30/$50/30% up to $250 per script Level 2: $15/$40/$60/40% up to $250 per script	Level 1: $10/$50/$90/30% up to $250 per script Level 2: $20/$60/$100/40% up to $250 per script	$15/$50/$80/20% up to $250 per script
Home delivery pharmacy[4] (tier 1/tier 2/tier 3/tier 4)	$10/$75/$125/30% up to $250 per script	$20/$125/$225/30% up to $250 per script	$30/$125/$200/20% up to $250 per script
Dental and vision	Pediatric dental and vision covered Adult dental not covered, eye exam only covered	Pediatric dental and vision covered Adult dental not covered, eye exam only covered	Pediatric dental and vision covered Adult dental not covered, eye exam only covered

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Small Group EmployeeElect product details – groups of 1 to 100 employees

Anthem PPO plans

	Gold plans		
Plan name	**Anthem Gold PPO 30/500/20% Ω**	**Anthem Gold PPO 35/500/25% Ω**	**Anthem Gold PPO 30/750/20% Ω**
Network (contract codes)	Prudent Buyer PPO (94JT) Select PPO (94JV)	Prudent Buyer PPO (8V5C) Select PPO (8V5D)	Prudent Buyer PPO (8V70) Select PPO (8V71)
In-network deductible (individual/family)	$500/$1,500	$500/$1,500	$750/$2,250
Out-of-network deductible (individual/family)	$2,000/$4,000	$2,000/$4,000	$2,000/$4,000
In-network coinsurance	20%	25%	20%
Out-of-network coinsurance	50%	50%	50%
In-network out-of-pocket maximum (individual/family)	$7,900/$15,800	$8,200/$16,400	$8,200/$16,400
Out-of-network out-of-pocket maximum (individual/family)	$15,800/$31,600	$16,400/$32,800	$16,400/$32,800
Office and virtual visits[1]: Primary care (PCP)/Specialist (SPC)	PCP: $30 SPC: $60	PCP: $35 SPC: $65	PCP: $30 SPC: $55
Virtual primary care and urgent/acute care services: Virtual care-only provider[2]	Covered in full	Covered in full	Covered in full
Urgent care (office)	$30	$35	$30
Emergency room (facility)	Deductible, then $250 and 20% coinsurance	Deductible, then $250 and 25% coinsurance	Deductible, then $250 and 20% coinsurance
Independent facility: ambulatory outpatient surgery center	Deductible, then $50 and 20% coinsurance	Deductible, then $50 and 25% coinsurance	Deductible, then $50 and 20% coinsurance
Hospital outpatient surgery facility	Deductible, then $250 and 20% coinsurance	Deductible, then $250 and 25% coinsurance	Deductible, then $250 and 20% coinsurance
Hospital inpatient admission	Deductible, then 20% coinsurance	Deductible, then 25% coinsurance	Deductible, then 20% coinsurance
Prescription drugs: network/drug list	Rx Choice Tiered Network with R90/ Select	Rx Choice Tiered Network with R90/ Select	Rx Choice Tiered Network with R90/ Select
Pharmacy deductible[3] (individual/family)	Tiers 1-4: No deductible	Tier 1: No deductible Tiers 2-4: $250/$500 Pharmacy deductible	Tier 1: No deductible Tiers 2-4: $250/$500 Pharmacy deductible
Retail pharmacy: 30-day supply (tier 1/tier 2/tier 3/tier 4)	Level 1: $10/$50/$90/30% up to $250 per script Level 2: $20/$60/$100/40% up to $250 per script	Level 1: $10/$50/$90/30% up to $250 per script Level 2: $20/$60/$100/40% up to $250 per script	Level 1: $10/$50/$90/30% up to $250 per script Level 2: $20/$60/$100/40% up to $250 per script
Home delivery pharmacy[4] (tier 1/tier 2/tier 3/tier 4)	$20/$125/$225/30% up to $250 per script	$20/$125/$225/30% up to $250 per script	$20/$125/$225/30% up to $250 per script
Dental and vision	Pediatric dental and vision covered Adult dental not covered, eye exam only covered	Pediatric dental and vision covered Adult dental not covered, eye exam only covered	Pediatric dental and vision covered Adult dental not covered, eye exam only covered

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† After deductible has been met on this plan, medical benefits are paid at 100% and pharmacy benefits apply member copays as listed.

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Anthem PPO plans

	Gold plans		Silver plans
Plan name	**Anthem Gold PPO 35/1000/20% Ω**	**Anthem Gold PPO 5/1500/30% Ω**	**Anthem Silver PPO 45/1750/40% Ω**
Network (contract codes)	Prudent Buyer PPO (8V7B) Select PPO (8V7A)	Prudent Buyer PPO (8V7T) Select PPO (8V7R)	Prudent Buyer PPO (8V87) Select PPO (8V88)
In-network deductible (individual/family)	$1,000/$3,000	$1,500/$3,000	$1,750/$3,500
Out-of-network deductible (individual/family)	$2,000/$4,000	$3,000/$6,000	$3,500/$7,000
In-network coinsurance	20%	30%	40%
Out-of-network coinsurance	50%	50%	50%
In-network out-of-pocket maximum (individual/family)	$8,200/$16,400	$8,100/$16,200	$9,100/$18,200
Out-of-network out-of-pocket maximum (individual/family)	$16,400/$32,800	$16,200/$32,400	$18,200/$36,400
Office and virtual visits[1]: Primary care (PCP)/Specialist (SPC)	PCP: $35 SPC: $60	PCP: $5 SPC: $65	PCP: $45 SPC: $95
Virtual primary care and urgent/acute care services: Virtual care-only provider[2]	Covered in full	Covered in full	Covered in full
Urgent care (office)	$35	$5	$45
Emergency room (facility)	Deductible, then $250 and 20% coinsurance	Deductible, then $250 and 30% coinsurance	Deductible, then $300 and 40% coinsurance
Independent facility: ambulatory outpatient surgery center	Deductible, then $50 and 20% coinsurance	Deductible, then $50 and 30% coinsurance	Deductible, then $50 and 40% coinsurance
Hospital outpatient surgery facility	Deductible, then $250 and 20% coinsurance	Deductible, then $250 and 30% coinsurance	Deductible, then $300 and 40% coinsurance
Hospital inpatient admission	Deductible, then 20% coinsurance	Deductible, then 30% coinsurance	Deductible, then 40% coinsurance
Prescription drugs: network/drug list	Rx Choice Tiered Network with R90/ Select	Rx Choice Tiered Network with R90/ Select	Rx Choice Tiered Network with R90/ Select
Pharmacy deductible[3] (individual/family)	Tier 1: No deductible Tiers 2-4: $300/$600 Pharmacy deductible	Tier 1: No deductible Tiers 2-4: $300/$600 Pharmacy deductible	Tier 1: No deductible Tiers 2-4: $300/$600 Pharmacy deductible
Retail pharmacy: 30-day supply (tier 1/tier 2/tier 3/tier 4)	Level 1: $5/$60/$110/30% up to $250 per script Level 2: $15/$70/$120/40% up to $250 per script	Level 1: $5/$60/$110/30% up to $250 per script Level 2: $15/$70/$120/40% up to $250 per script	Level 1: $15/$70/$110/30% up to $250 per script Level 2: $20/$80/$120/40% up to $250 per script
Home delivery pharmacy[4] (tier 1/tier 2/tier 3/tier 4)	$10/$150/$275/30% up to $250 per script	$10/$150/$275/30% up to $250 per script	$30/$175/$275/30% up to $250 per script
Dental and vision	Pediatric dental and vision covered Adult dental not covered, eye exam only covered	Pediatric dental and vision covered Adult dental not covered, eye exam only covered	Pediatric dental and vision covered Adult dental not covered, eye exam only covered

Footnotes

Ω Site of Service plan may have reduced cost shares for laboratory services received at an independent lab; radiology and advanced diagnostic imaging services received at an independent radiology center; and outpatient surgery received at an ambulatory surgical center.Ω

◊ These plans have a different deductible amount if the subscriber is enrolled as self only or has enrolled dependents in the plan (Subscriber only/Subscriber enrolled with a Family/Family). Plans comply with AB1305 and IRS minimum deductible and out-of-pocket maximum requirements for embedded high-deductible health plans.

† After deductible has been met on this plan, medical benefits are paid at 100% and pharmacy benefits apply member copays as listed.

‡ Deductible waived for drugs on the PreventiveRx Plus drug list.

1 Primary care physician (PCP) and Specialist (SPC) cost share applies to medical office visits and virtual visits with a member's regular PCP or SPC. NOTE: The PCP cost share does not apply to virtual primary care visits for **Virtual Access Plus** and **Vivity HMO plans** which are covered in full.

2 Cost share may apply to virtual visits for urgent/acute medical and behavioral health (mental health/substance use disorder) services from the virtual care only providers available through Sydney Health and our website. In addition, virtual visits for Building Healthy Families Breastfeeding Support and EAP counseling visits from our virtual care-only providers are included with all medical plans at no additional cost.

3 For plans with a deductible, the pharmacy cost share applies after deductible for the tiers as listed. For plans with a separate pharmacy deductible, the deductible is combined for retail and home delivery.

4 Home delivery program typically covers up to a 90-day supply for tier 1, tier 2 and tier 3 drugs and up to a 30-day supply for tier 4 drugs.

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Small Group EmployeeElect product details – groups of 1 to 100 employees

Anthem PPO plans

	Silver plans		
Plan name	**Anthem Silver PPO 55/1950/35% Ω**	**Anthem Silver PPO 50/2200/40% Ω**	**Anthem Silver Select PPO 55/2500/35%**
Network (contract codes)	Prudent Buyer PPO (8V91) Select PPO (8V8Z)	Prudent Buyer PPO (8V9F) Select PPO (8V9H)	Select PPO (8ZXD)
In-network deductible (individual/family)	$1,950/$3,900	$2,200/$4,400	$2,500/$5,000
Out-of-network deductible (individual/family)	$3,900/$7,800	$4,400/$8,800	$5,000/$10,000
In-network coinsurance	35%	40%	35%
Out-of-network coinsurance	50%	50%	50%
In-network out-of-pocket maximum (individual/family)	$10,150/$20,300	$8,600/$17,200	$8,600/$17,200
Out-of-network out-of-pocket maximum (individual/family)	$20,300/$40,600	$17,200/$34,400	$17,200/$34,400
Office and virtual visits[1]: Primary care (PCP)/Specialist (SPC)	PCP: $55 SPC: $90	PCP: $50 SPC: $90	PCP: $55 SPC: $90
Virtual primary care and urgent/acute care services: Virtual care-only provider[2]	Covered in full	Covered in full	Covered in full
Urgent care (office)	$55	$50	$55
Emergency room (facility)	Deductible, then $350 and 35% coinsurance	Deductible, then $350 and 40% coinsurance	Deductible, then 35% coinsurance
Independent facility: ambulatory outpatient surgery center	Deductible, then $50 and 35% coinsurance	Deductible, then $50 and 40% coinsurance	Deductible, then 35% coinsurance
Hospital outpatient surgery facility	Deductible, then $250 and 35% coinsurance	Deductible, then $250 and 40% coinsurance	Deductible, then 35% coinsurance
Hospital inpatient admission	Deductible, then 35% coinsurance	Deductible, then 40% coinsurance	Deductible, then 35% coinsurance
Prescription drugs: network/drug list	Rx Choice Tiered Network with R90/ Select	Rx Choice Tiered Network with R90/ Select	Advantage with R90/Select
Pharmacy deductible[3] (individual/family)	Tier 1: No deductible Tiers 2-4: $300/$600 Pharmacy deductible	Tier 1: No deductible Tiers 2-4: $300/$600 Pharmacy deductible	Tier 1: No deductible Tiers 2-4: $300/$600 Pharmacy deductible
Retail pharmacy: 30-day supply (tier 1/tier 2/tier 3/tier 4)	Level 1: $15/$70/$110/30% up to $250 per script Level 2: $20/$80/$120/40% up to $250 per script	Level 1: $15/$70/$110/30% up to $250 per script Level 2: $20/$80/$120/40% up to $250 per script	$20/$75/$105/30% up to $250 per script
Home delivery pharmacy[4] (tier 1/tier 2/tier 3/tier 4)	$30/$175/$275/30% up to $250 per script	$30/$175/$275/30% up to $250 per script	$40/$188/$263/30% up to $250 per script
Dental and vision	Pediatric dental and vision covered Adult dental not covered, eye exam only covered	Pediatric dental and vision covered Adult dental not covered, eye exam only covered	Pediatric dental and vision covered Adult dental not covered, eye exam only covered

Footnotes

Ω Site of Service plan may have reduced cost shares for laboratory services received at an independent lab; radiology and advanced diagnostic imaging services received at an independent radiology center; and outpatient surgery received at an ambulatory surgical center.Ω

◊ These plans have a different deductible amount if the subscriber is enrolled as self only or has enrolled dependents in the plan (Subscriber only/Subscriber enrolled with a Family/Family). Plans comply with AB1305 and IRS minimum deductible and out-of-pocket maximum requirements for embedded high-deductible health plans.

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‡ Deductible waived for drugs on the PreventiveRx Plus drug list.

1 Primary care physician (PCP) and Specialist (SPC) cost share applies to medical office visits and virtual visits with a member's regular PCP or SPC. NOTE: The PCP cost share does not apply to virtual primary care visits for **Virtual Access Plus** and **Vivity HMO plans** which are covered in full.

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Small Group EmployeeElect product details – groups of 1 to 100 employees

Anthem PPO plans

	Silver plans	Bronze plans	
Plan name	**Anthem Silver PPO 55/2500/45% Ω**	**Anthem Bronze PPO 4600/50% Ω**	**Anthem Bronze PPO 40/6200/40% Ω**
Network (contract codes)	Prudent Buyer PPO (8V9X) Select PPO (8V9W)	Prudent Buyer PPO (8VDB) Select PPO (8VDJ)	Prudent Buyer PPO (8VAN) Select PPO (8VAP)
In-network deductible (individual/family)	$2,500/$5,000	$4,600/$9,200	$6,200/$12,400
Out-of-network deductible (individual/family)	$5,000/$10,000	$9,200/$18,400	$12,400/$24,800
In-network coinsurance	45%	50%	40%
Out-of-network coinsurance	50%	50%	50%
In-network out-of-pocket maximum (individual/family)	$8,700/$17,400	$8,100/$16,200	$8,700/$17,400
Out-of-network out-of-pocket maximum (individual/family)	$17,400/$34,800	$16,200/$32,400	$17,400/$34,800
Office and virtual visits[1]: Primary care (PCP)/Specialist (SPC)	PCP: $55 SPC: $90	Deductible, then 50% coinsurance	PCP: Deductible, then $40 SPC: Deductible, then $80
Virtual primary care and urgent/acute care services: Virtual care-only provider[2]	Covered in full	Deductible, then covered in full	Covered in full
Urgent care (office)	$55	Deductible, then 50% coinsurance	Deductible, then $40
Emergency room (facility)	Deductible, then $100 and 45% coinsurance	Deductible, then 50% coinsurance	Deductible, then $250 and 40% coinsurance
Independent facility: ambulatory outpatient surgery center	Deductible, then $50 and 45% coinsurance	Deductible, then 40% coinsurance	Deductible, then $50 and 40% coinsurance
Hospital outpatient surgery facility	Deductible, then $250 and 45% coinsurance	Deductible, then 50% coinsurance	Deductible, then $250 and 40% coinsurance
Hospital inpatient admission	Deductible, then 45% coinsurance	Deductible, then 50% coinsurance	Deductible, then 40% coinsurance
Prescription drugs: network/drug list	Rx Choice Tiered Network with R90/ Select	Rx Choice Tiered Network with R90/ Select	Rx Choice Tiered Network with R90/ Select
Pharmacy deductible[3] (individual/family)	Tier 1: No deductible Tiers 2-4: $200/$400 Pharmacy deductible	Tier 1: No deductible Tiers 2-4: Medical deductible applies	Tier 1: No deductible Tiers 2-4: Medical deductible applies
Retail pharmacy: 30-day supply (tier 1/tier 2/tier 3/tier 4)	Level 1: $15/$70/$110/30% up to $250 per script Level 2: $20/$80/$120/40% up to $250 per script	Level 1: $20/$80/$120/30% up to $400 per script Level 2: $20/$90/$130/40% up to $500 per script	Level 1: $20/$80/$120/30% up to $400 per script Level 2: $20/$90/$130/40% up to $500 per script
Home delivery pharmacy[4] (tier 1/tier 2/tier 3/tier 4)	$30/$175/$275/30% up to $250 per script	$40/$200/$300/30% up to $400 per script	$40/$200/$300/30% up to $400 per script
Dental and vision	Pediatric dental and vision covered Adult dental not covered, eye exam only covered	Pediatric dental and vision covered Adult dental not covered, eye exam only covered	Pediatric dental and vision covered Adult dental not covered, eye exam only covered

Footnotes

Ω Site of Service plan may have reduced cost shares for laboratory services received at an independent lab; radiology and advanced diagnostic imaging services received at an independent radiology center; and outpatient surgery received at an ambulatory surgical center.Ω

◊ These plans have a different deductible amount if the subscriber is enrolled as self only or has enrolled dependents in the plan (Subscriber only/Subscriber enrolled with a Family/Family). Plans comply with AB1305 and IRS minimum deductible and out-of-pocket maximum requirements for embedded high-deductible health plans.

† After deductible has been met on this plan, medical benefits are paid at 100% and pharmacy benefits apply member copays as listed.

‡ Deductible waived for drugs on the PreventiveRx Plus drug list.

1 Primary care physician (PCP) and Specialist (SPC) cost share applies to medical office visits and virtual visits with a member's regular PCP or SPC. NOTE: The PCP cost share does not apply to virtual primary care visits for **Virtual Access Plus** and **Vivity HMO plans** which are covered in full.

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4 Home delivery program typically covers up to a 90-day supply for tier 1, tier 2 and tier 3 drugs and up to a 30-day supply for tier 4 drugs.

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Small Group EmployeeElect product details – groups of 1 to 100 employees

Anthem PPO plans

	Bronze plans		
Plan name	**Anthem Bronze PPO 70/6600/35% Ω**	**Anthem Bronze PPO 60/6850/40% Ω**	**Anthem Bronze PPO 75/7300/40% Ω**
Network (contract codes)	Prudent Buyer PPO (8VB9) Select PPO (8VB8)	Prudent Buyer PPO (8VAZ) Select PPO (8VAY)	Prudent Buyer PPO (8VAC) Select PPO (8VAB)
In-network deductible (individual/family)	$6,600/$13,200	$6,850/$13,700	$7,300/$14,600
Out-of-network deductible (individual/family)	$13,200/$26,400	$13,700/$27,400	$14,600/$29,200
In-network coinsurance	35%	40%	40%
Out-of-network coinsurance	50%	50%	50%
In-network out-of-pocket maximum (individual/family)	$8,900/$17,800	$8,200/$16,400	$10,150/$20,300
Out-of-network out-of-pocket maximum (individual/family)	$17,800/$35,600	$16,400/$32,800	$20,300/$40,600
Office and virtual visits[1]: Primary care (PCP)/Specialist (SPC)	PCP: Deductible, then $70 SPC: Deductible, then $85	PCP: Deductible, then $60 SPC: Deductible, then $80	PCP: $75 SPC: $110
Virtual primary care and urgent/acute care services: Virtual care-only provider[2]	Covered in full	Covered in full	Covered in full
Urgent care (office)	Deductible, then $70	Deductible, then $60	$75
Emergency room (facility)	Deductible, then $250 and 35% coinsurance	Deductible, then $250 and 40% coinsurance	Deductible, then $250 and 40% coinsurance
Independent facility: ambulatory outpatient surgery center	Deductible, then $50 and 35% coinsurance	Deductible, then $50 and 40% coinsurance	Deductible, then $50 and 40% coinsurance
Hospital outpatient surgery facility	Deductible, then $250 and 35% coinsurance	Deductible, then $250 and 40% coinsurance	Deductible, then $250 and 40% coinsurance
Hospital inpatient admission	Deductible, then 35% coinsurance	Deductible, then 40% coinsurance	Deductible, then 40% coinsurance
Prescription drugs: network/drug list	Rx Choice Tiered Network with R90/ Select	Rx Choice Tiered Network with R90/ Select	Rx Choice Tiered Network with R90/ Select
Pharmacy deductible[3] (individual/family)	Tier 1: No deductible Tiers 2-4: Medical deductible applies	Tier 1: No deductible Tiers 2-4: $650/$1,300 Pharmacy deductible	Tier 1: No deductible Tiers 2-4: $650/$1,300 Pharmacy deductible
Retail pharmacy: 30-day supply (tier 1/tier 2/tier 3/tier 4)	Level 1: $20/$80/$120/30% up to $400 per script Level 2: $20/$90/$130/40% up to $500 per script	Level 1: $20/$90/$160/30% up to $400 per script Level 2: $20/$100/$170/40% up to $500 per script	Level 1: $20/$90/$160/30% up to $400 per script Level 2: $20/$100/$170/40% up to $500 per script
Home delivery pharmacy[4] (tier 1/tier 2/tier 3/tier 4)	$40/$200/$300/30% up to $400 per script	$40/$225/$400/30% up to $400 per script	$40/$225/$400/30% up to $400 per script
Dental and vision	Pediatric dental and vision covered Adult dental not covered, eye exam only covered	Pediatric dental and vision covered Adult dental not covered, eye exam only covered	Pediatric dental and vision covered Adult dental not covered, eye exam only covered

Footnotes

Ω Site of Service plan may have reduced cost shares for laboratory services received at an independent lab; radiology and advanced diagnostic imaging services received at an independent radiology center; and outpatient surgery received at an ambulatory surgical center.Ω

◊ These plans have a different deductible amount if the subscriber is enrolled as self only or has enrolled dependents in the plan (Subscriber only/Subscriber enrolled with a Family/Family). Plans comply with AB1305 and IRS minimum deductible and out-of-pocket maximum requirements for embedded high-deductible health plans.

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Small Group EmployeeElect product details – groups of 1 to 100 employees

Anthem PPO HSA plans

	Gold plans		Silver plans
Plan name	**Anthem Gold PPO HSA/H 1900/3400/3800 15% PrevRx Ω,◊**	**Anthem Gold PPO HSA/H 1900/3400/3800 15% PrevRx Ω,◊**	**Anthem Silver PPO HSA/H 2300/3400/4600 30% PrevRx Ω,◊**
Network (contract codes)	Prudent Buyer PPO (8VBM) Select PPO (8VBJ)	Prudent Buyer PPO (8VBL) Select PPO (8VBK)	Prudent Buyer PPO (8VC4) Select PPO (8VCF)
In-network deductible (individual/family)	$1,900/$3,800	$3,400/$3,800	$2,300/$4,600
Out-of-network deductible (individual/family)	$3,800/$7,600	$6,800/$7,600	$4,600/$9,200
In-network coinsurance	15%	15%	30%
Out-of-network coinsurance	50%	50%	50%
In-network out-of-pocket maximum (individual/family)	$4,500/$9,000	$4,500/$9,000	$8,450/$16,900
Out-of-network out-of-pocket maximum (individual/family)	$9,000/$18,000	$9,000/$18,000	$16,900/$33,800
Office and virtual visits[1]: Primary care (PCP)/Specialist (SPC)	Deductible, then 15% coinsurance	Deductible, then 15% coinsurance	Deductible, then 30% coinsurance
Virtual primary care and urgent/acute care services: Virtual care-only provider[2]	Deductible, then covered in full	Deductible, then covered in full	Deductible, then covered in full
Urgent care (office)	Deductible, then 15% coinsurance	Deductible, then 15% coinsurance	Deductible, then 30% coinsurance
Emergency room (facility)	Deductible, then 15% coinsurance	Deductible, then 15% coinsurance	Deductible, then 30% coinsurance
Independent facility: ambulatory outpatient surgery center	Deductible, then $50 and 15% coinsurance	Deductible, then $50 and 15% coinsurance	Deductible, then $50 and 30% coinsurance
Hospital outpatient surgery facility	Deductible, then $250 and 15% coinsurance	Deductible, then $250 and 15% coinsurance	Deductible, then $250 and 30% coinsurance
Hospital inpatient admission	Deductible, then 15% coinsurance	Deductible, then 15% coinsurance	Deductible, then 30% coinsurance
Prescription drugs: network/drug list	Rx Choice Tiered Network with R90/ Select	Rx Choice Tiered Network with R90/ Select	Rx Choice Tiered Network with R90/ Select
Pharmacy deductible[3] (individual/family)	Tiers 1-4: Medical deductible applies ‡	Tiers 1-4: Medical deductible applies ‡	Tiers 1-4: Medical deductible applies ‡
Retail pharmacy: 30-day supply (tier 1/tier 2/tier 3/tier 4)	Level 1: $10/$30/$50/30% up to $250 per script Level 2: $20/$40/$60/40% up to $250 per script	Level 1: $10/$30/$50/30% up to $250 per script Level 2: $20/$40/$60/40% up to $250 per script	Level 1: $15/$70/$110/30% up to $250 per script Level 2: $20/$80/$120/40% up to $250 per script
Home delivery pharmacy[4] (tier 1/tier 2/tier 3/tier 4)	$20/$75/$125/30% up to $250 per script	$20/$75/$125/30% up to $250 per script	$30/$175/$275/30% up to $250 per script
Dental and vision	Pediatric dental and vision covered Adult dental not covered, eye exam only covered	Pediatric dental and vision covered Adult dental not covered, eye exam only covered	Pediatric dental and vision covered Adult dental not covered, eye exam only covered

Footnotes

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‡ Deductible waived for drugs on the PreventiveRx Plus drug list.

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Small Group EmployeeElect product details – groups of 1 to 100 employees

Anthem PPO HSA plans

	Silver plans		
Plan name	**Anthem Silver PPO HSA/H 2300/3400/4600 30% PrevRx Ω,◊**	**Anthem Silver PPO HSA/H 2600/3400/5200 35% PrevRx Ω,◊**	**Anthem Silver PPO HSA/H 2600/3400/5200 35% PrevRx Ω,◊**
Network (contract codes)	Prudent Buyer PPO (8VC5) Select PPO (8VCG)	Prudent Buyer PPO (8VCR) Select PPO (8VD2)	Prudent Buyer PPO (8VCS) Select PPO (8VD1)
In-network deductible (individual/family)	$3,400/$4,600	$2,600/$5,200	$3,400/$5,200
Out-of-network deductible (individual/family)	$6,800/$9,200	$5,200/$10,400	$6,800/$10,400
In-network coinsurance	30%	35%	35%
Out-of-network coinsurance	50%	50%	50%
In-network out-of-pocket maximum (individual/family)	$8,450/$16,900	$8,450/$16,900	$8,450/$16,900
Out-of-network out-of-pocket maximum (individual/family)	$16,900/$33,800	$16,900/$33,800	$16,900/$33,800
Office and virtual visits[1]: Primary care (PCP)/Specialist (SPC)	Deductible, then 30% coinsurance	Deductible, then 35% coinsurance	Deductible, then 35% coinsurance
Virtual primary care and urgent/acute care services: Virtual care-only provider[2]	Deductible, then covered in full	Deductible, then covered in full	Deductible, then covered in full
Urgent care (office)	Deductible, then 30% coinsurance	Deductible, then 35% coinsurance	Deductible, then 35% coinsurance
Emergency room (facility)	Deductible, then 30% coinsurance	Deductible, then 35% coinsurance	Deductible, then 35% coinsurance
Independent facility: ambulatory outpatient surgery center	Deductible, then $50 and 30% coinsurance	Deductible, then $50 and 35% coinsurance	Deductible, then $50 and 35% coinsurance
Hospital outpatient surgery facility	Deductible, then $250 and 30% coinsurance	Deductible, then $250 and 35% coinsurance	Deductible, then $250 and 35% coinsurance
Hospital inpatient admission	Deductible, then 30% coinsurance	Deductible, then 35% coinsurance	Deductible, then 35% coinsurance
Prescription drugs: network/drug list	Rx Choice Tiered Network with R90/ Select	Rx Choice Tiered Network with R90/ Select	Rx Choice Tiered Network with R90/ Select
Pharmacy deductible[3] (individual/family)	Tiers 1-4: Medical deductible applies ‡	Tiers 1-4: Medical deductible applies ‡	Tiers 1-4: Medical deductible applies ‡
Retail pharmacy: 30-day supply (tier 1/tier 2/tier 3/tier 4)	Level 1: $15/$70/$110/30% up to $250 per script Level 2: $20/$80/$120/40% up to $250 per script	Level 1: $15/$70/$110/30% up to $250 per script Level 2: $20/$80/$120/40% up to $250 per script	Level 1: $15/$70/$110/30% up to $250 per script Level 2: $20/$80/$120/40% up to $250 per script
Home delivery pharmacy[4] (tier 1/tier 2/tier 3/tier 4)	$30/$175/$275/30% up to $250 per script	$30/$175/$275/30% up to $250 per script	$30/$175/$275/30% up to $250 per script
Dental and vision	Pediatric dental and vision covered Adult dental not covered, eye exam only covered	Pediatric dental and vision covered Adult dental not covered, eye exam only covered	Pediatric dental and vision covered Adult dental not covered, eye exam only covered

Footnotes

Ω Site of Service plan may have reduced cost shares for laboratory services received at an independent lab; radiology and advanced diagnostic imaging services received at an independent radiology center; and outpatient surgery received at an ambulatory surgical center.Ω

◊ These plans have a different deductible amount if the subscriber is enrolled as self only or has enrolled dependents in the plan (Subscriber only/Subscriber enrolled with a Family/Family). Plans comply with AB1305 and IRS minimum deductible and out-of-pocket maximum requirements for embedded high-deductible health plans.

† After deductible has been met on this plan, medical benefits are paid at 100% and pharmacy benefits apply member copays as listed.

‡ Deductible waived for drugs on the PreventiveRx Plus drug list.

1 Primary care physician (PCP) and Specialist (SPC) cost share applies to medical office visits and virtual visits with a member's regular PCP or SPC. NOTE: The PCP cost share does not apply to virtual primary care visits for **Virtual Access Plus** and **Vivity HMO plans** which are covered in full.

2 Cost share may apply to virtual visits for urgent/acute medical and behavioral health (mental health/substance use disorder) services from the virtual care only providers available through Sydney Health and our website. In addition, virtual visits for Building Healthy Families Breastfeeding Support and EAP counseling visits from our virtual care-only providers are included with all medical plans at no additional cost.

3 For plans with a deductible, the pharmacy cost share applies after deductible for the tiers as listed. For plans with a separate pharmacy deductible, the deductible is combined for retail and home delivery.

4 Home delivery program typically covers up to a 90-day supply for tier 1, tier 2 and tier 3 drugs and up to a 30-day supply for tier 4 drugs.

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Small Group EmployeeElect product details – groups of 1 to 100 employees

Anthem PPO HSA plans

	Bronze plans		
Plan name	**Anthem Bronze PPO 6000/45% w/HSA PrevRx Ω**	**Anthem Bronze PPO 6700/0% w/HSA PrevRx**	**Anthem Bronze Select PPO 7200/0% w/HSA**
Network (contract codes)	Prudent Buyer PPO (8VDP) Select PPO (8VDU)	Prudent Buyer PPO (8VE4) Select PPO (8VE9)	Select PPO (8ZXN)
In-network deductible (individual/family)	$6,000/$12,000	$6,700/$13,400	$7,200/$14,400
Out-of-network deductible (individual/family)	$12,000/$24,000	$13,400/$26,800	$14,400/$28,800
In-network coinsurance	45%	0%	0%
Out-of-network coinsurance	50%	50%	50%
In-network out-of-pocket maximum (individual/family)	$7,400/$14,800	$7,800/$15,600	$7,200/$14,400
Out-of-network out-of-pocket maximum (individual/family)	$14,800/$29,600	$15,600/$31,200	$18,000/$36,000
Office and virtual visits[1]: Primary care (PCP)/Specialist (SPC)	Deductible, then 45% coinsurance	Deductible, then 0% coinsurance	Deductible, then 0% coinsurance
Virtual primary care and urgent/acute care services: Virtual care-only provider[2]	Deductible, then covered in full	Deductible, then covered in full	Deductible, then covered in full
Urgent care (office)	Deductible, then 45% coinsurance	Deductible, then 0% coinsurance	Deductible, then 0% coinsurance
Emergency room (facility)	Deductible, then 45% coinsurance	Deductible, then 0% coinsurance	Deductible, then 0% coinsurance
Independent facility: ambulatory outpatient surgery center	Deductible, then $50 and 45% coinsurance	Deductible, then 0% coinsurance	Deductible, then 0% coinsurance
Hospital outpatient surgery facility	Deductible, then $250 and 45% coinsurance	Deductible, then 0% coinsurance	Deductible, then 0% coinsurance
Hospital inpatient admission	Deductible, then 45% coinsurance	Deductible, then 0% coinsurance	Deductible, then 0% coinsurance
Prescription drugs: network/drug list	Rx Choice Tiered Network with R90/ Select	Rx Choice Tiered Network with R90/ Select	Advantage with R90/Select
Pharmacy deductible[3] (individual/family)	Tiers 1-4: Medical deductible applies ‡	Tiers 1-4: Medical deductible applies ‡	Tiers 1-4: Medical deductible applies
Retail pharmacy: 30-day supply (tier 1/tier 2/tier 3/tier 4)	Level 1: $20/$90/$160/30% up to $400 per script Level 2: $20/$100/$170/40% up to $500 per script	Level 1: $20/$90/$160/30% up to $400 per script Level 2: $20/$100/$170/40% up to $500 per script	0%
Home delivery pharmacy[4] (tier 1/tier 2/tier 3/tier 4)	$40/$225/$400/30% up to $400 per script	$40/$225/$400/30% up to $400 per script	0%
Dental and vision	Pediatric dental and vision covered Adult dental not covered, eye exam only covered	Pediatric dental and vision covered Adult dental not covered, eye exam only covered	Pediatric dental and vision covered Adult dental not covered, eye exam only covered

Footnotes

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◊ These plans have a different deductible amount if the subscriber is enrolled as self only or has enrolled dependents in the plan (Subscriber only/Subscriber enrolled with a Family/Family). Plans comply with AB1305 and IRS minimum deductible and out-of-pocket maximum requirements for embedded high-deductible health plans.

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‡ Deductible waived for drugs on the PreventiveRx Plus drug list.

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3 For plans with a deductible, the pharmacy cost share applies after deductible for the tiers as listed. For plans with a separate pharmacy deductible, the deductible is combined for retail and home delivery.

4 Home delivery program typically covers up to a 90-day supply for tier 1, tier 2 and tier 3 drugs and up to a 30-day supply for tier 4 drugs.

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Small Group EmployeeElect product details – groups of 1 to 100 employees

Anthem HMO plans

	Platinum plans		
Plan name	**Anthem Platinum HMO 20 Ω**	**Anthem Platinum HMO 25 Ω**	**Anthem Platinum HMO 30 Ω**
Network (contract codes)	California Care HMO (901E) Small Group Priority Select HMO (901B) Select HMO (901D)	California Care HMO (901W) Small Group Priority Select HMO (901U) Select HMO (901V)	California Care HMO (902M) Small Group Priority Select HMO (902L) Select HMO (902K)
In-network deductible (individual/family)	$0/$0	$0/$0	$0/$0
Out-of-network deductible (individual/family)	Not applicable	Not applicable	Not applicable
In-network coinsurance	0%	0%	0%
Out-of-network coinsurance	Not applicable	Not applicable	Not applicable
In-network out-of-pocket maximum (individual/family)	$2,100/$4,200	$2,300/$4,600	$2,700/$5,400
Out-of-network out-of-pocket maximum (individual/family)	Not applicable	Not applicable	Not applicable
Office and virtual visits[1]: Primary care (PCP)/Specialist (SPC)	PCP: $20 SPC: $40	PCP: $25 SPC: $50	PCP: $30 SPC: $50
Virtual primary care and urgent/acute care services: Virtual care-only provider[2]	Covered in full	Covered in full	Covered in full
Urgent care (office)	$20	$25	$30
Emergency room (facility)	$300	$275	$275
Independent facility: ambulatory outpatient surgery center	$100	$150	$250
Hospital outpatient surgery facility	$150	$200	$300
Hospital inpatient admission	$500 per admission	$300 per day up to 3 days per admission	$450 per day up to 4 days per admission
Prescription drugs: network/drug list	Rx Choice Tiered Network with R90/ Select	Rx Choice Tiered Network with R90/ Select	Rx Choice Tiered Network with R90/ Select
Pharmacy deductible[3] (individual/family)	Tiers 1-4: No deductible	Tiers 1-4: No deductible	Tiers 1-4: No deductible
Retail pharmacy: 30-day supply (tier 1/tier 2/tier 3/tier 4)	Level 1: $5/$20/$50/30% up to $250 per script Level 2: $15/$30/$60/40% up to $250 per script	Level 1: $5/$20/$50/30% up to $250 per script Level 2: $15/$30/$60/40% up to $250 per script	Level 1: $5/$30/$50/30% up to $250 per script Level 2: $15/$40/$60/40% up to $250 per script
Home delivery pharmacy[4] (tier 1/tier 2/tier 3/tier 4)	$10/$50/$125/30% up to $250 per script	$10/$50/$125/30% up to $250 per script	$10/$75/$125/30% up to $250 per script
Dental and vision	Pediatric dental and vision covered Adult dental not covered, eye exam only covered	Pediatric dental and vision covered Adult dental not covered, eye exam only covered	Pediatric dental and vision covered Adult dental not covered, eye exam only covered

Footnotes

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◊ These plans have a different deductible amount if the subscriber is enrolled as self only or has enrolled dependents in the plan (Subscriber only/Subscriber enrolled with a Family/Family). Plans comply with AB1305 and IRS minimum deductible and out-of-pocket maximum requirements for embedded high-deductible health plans.

† After deductible has been met on this plan, medical benefits are paid at 100% and pharmacy benefits apply member copays as listed.

‡ Deductible waived for drugs on the PreventiveRx Plus drug list.

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Small Group EmployeeElect product details – groups of 1 to 100 employees

Anthem HMO plans

	Gold plans		
Plan name	**Anthem Gold HMO 30 Ω**	**Anthem Gold HMO 35 Ω**	**Anthem Gold HMO 35/1250/20% Ω**
Network (contract codes)	California Care HMO (903C) Small Group Priority Select HMO (903B) Select HMO (903A)	California Care HMO (903R) Small Group Priority Select HMO (903S) Select HMO (903T)	California Care HMO (904W) Small Group Priority Select HMO (904X) Select HMO (904Y)
In-network deductible (individual/family)	$0/$0	$0/$0	$1,250/$2,500
Out-of-network deductible (individual/family)	Not applicable	Not applicable	Not applicable
In-network coinsurance	0%	0%	20%
Out-of-network coinsurance	Not applicable	Not applicable	Not applicable
In-network out-of-pocket maximum (individual/family)	$7,500/$15,000	$6,750/$13,500	$8,600/$17,200
Out-of-network out-of-pocket maximum (individual/family)	Not applicable	Not applicable	Not applicable
Office and virtual visits[1]: Primary care (PCP)/Specialist (SPC)	PCP: $30 SPC: $60	PCP: $35 SPC: $70	PCP: $35 SPC: $60
Virtual primary care and urgent/acute care services: Virtual care-only provider[2]	Covered in full	Covered in full	Covered in full
Urgent care (office)	$30	$35	$35
Emergency room (facility)	$325	$325	Deductible, then $300 and 20% coinsurance
Independent facility: ambulatory outpatient surgery center	$300	$450	Deductible, then $500
Hospital outpatient surgery facility	$450	$550	Deductible, then 20% coinsurance
Hospital inpatient admission	$600 per day up to 4 days per admission	$750 per day up to 4 days per admission	Deductible, then 20% coinsurance
Prescription drugs: network/drug list	Rx Choice Tiered Network with R90/ Select	Rx Choice Tiered Network with R90/ Select	Rx Choice Tiered Network with R90/ Select
Pharmacy deductible[3] (individual/family)	Tiers 1-4: No deductible	Tiers 1-4: No deductible	Tiers 1-4: No deductible
Retail pharmacy: 30-day supply (tier 1/tier 2/tier 3/tier 4)	Level 1: $10/$50/$90/30% up to $250 per script Level 2: $20/$60/$100/40% up to $250 per script	Level 1: $10/$50/$90/30% up to $250 per script Level 2: $20/$60/$100/40% up to $250 per script	Level 1: $10/$50/$90/30% up to $250 per script Level 2: $20/$60/$100/40% up to $250 per script
Home delivery pharmacy[4] (tier 1/tier 2/tier 3/tier 4)	$20/$125/$225/30% up to $250 per script	$20/$125/$225/30% up to $250 per script	$20/$125/$225/30% up to $250 per script
Dental and vision	Pediatric dental and vision covered Adult dental not covered, eye exam only covered	Pediatric dental and vision covered Adult dental not covered, eye exam only covered	Pediatric dental and vision covered Adult dental not covered, eye exam only covered

Footnotes

Ω Site of Service plan may have reduced cost shares for laboratory services received at an independent lab; radiology and advanced diagnostic imaging services received at an independent radiology center; and outpatient surgery received at an ambulatory surgical center.Ω

◊ These plans have a different deductible amount if the subscriber is enrolled as self only or has enrolled dependents in the plan (Subscriber only/Subscriber enrolled with a Family/Family). Plans comply with AB1305 and IRS minimum deductible and out-of-pocket maximum requirements for embedded high-deductible health plans.

† After deductible has been met on this plan, medical benefits are paid at 100% and pharmacy benefits apply member copays as listed.

‡ Deductible waived for drugs on the PreventiveRx Plus drug list.

1 Primary care physician (PCP) and Specialist (SPC) cost share applies to medical office visits and virtual visits with a member's regular PCP or SPC. NOTE: The PCP cost share does not apply to virtual primary care visits for **Virtual Access Plus** and **Vivity HMO plans** which are covered in full.

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3 For plans with a deductible, the pharmacy cost share applies after deductible for the tiers as listed. For plans with a separate pharmacy deductible, the deductible is combined for retail and home delivery.

4 Home delivery program typically covers up to a 90-day supply for tier 1, tier 2 and tier 3 drugs and up to a 30-day supply for tier 4 drugs.

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Small Group EmployeeElect product details – groups of 1 to 100 employees

Anthem HMO plans

	Gold plans	Silver plans	
Plan name	**Anthem Gold HMO 35/500/20% Ω**	**Anthem Silver HMO 55 Ω**	**Anthem Silver HMO 60/2500/45% Ω**
Network (contract codes)	California Care HMO (904G) Small Group Priority Select HMO (904H) Select HMO (904F)	California Care HMO (94K7) Select HMO (94K8)	California Care HMO (94KJ) Select HMO (94KK)
In-network deductible (individual/family)	$500/$1,500	$0/$0	$2,500/$5,000
Out-of-network deductible (individual/family)	Not applicable	Not applicable	Not applicable
In-network coinsurance	20%	0%	45%
Out-of-network coinsurance	Not applicable	Not applicable	Not applicable
In-network out-of-pocket maximum (individual/family)	$8,450/$16,900	$9,200/$18,400	$10,150/$20,300
Out-of-network out-of-pocket maximum (individual/family)	Not applicable	Not applicable	Not applicable
Office and virtual visits[1]: Primary care (PCP)/Specialist (SPC)	PCP: $35 SPC: $55	PCP: $55 SPC: $110	PCP: $60 SPC: $95
Virtual primary care and urgent/acute care services: Virtual care-only provider[2]	Covered in full	Covered in full	Covered in full
Urgent care (office)	$35	$55	$60
Emergency room (facility)	Deductible, then $300 and 20% coinsurance	$500	Deductible, then $500 and 45% coinsurance
Independent facility: ambulatory outpatient surgery center	Deductible, then $500	$550	Deductible, then $600
Hospital outpatient surgery facility	Deductible, then 20% coinsurance	$600	Deductible, then 45% coinsurance
Hospital inpatient admission	Deductible, then 20% coinsurance	$750 per day up to 5 days per admission	Deductible, then 45% coinsurance
Prescription drugs: network/drug list	Rx Choice Tiered Network with R90/ Select	Rx Choice Tiered Network with R90/ Select	Rx Choice Tiered Network with R90/ Select
Pharmacy deductible[3] (individual/family)	Tiers 1-4: No deductible	Tier 1: No deductible Tiers 2-4: $400/$800 Pharmacy deductible	Tier 1: No deductible Tiers 2-4: $200/$400 Pharmacy deductible
Retail pharmacy: 30-day supply (tier 1/tier 2/tier 3/tier 4)	Level 1: $10/$50/$90/30% up to $250 per script Level 2: $20/$60/$100/40% up to $250 per script	Level 1: $20/$95/$150/30% up to $250 per script Level 2: $25/$105/$160/40% up to $250 per script	Level 1: $10/$70/$110/30% up to $250 per script Level 2: $20/$80/$120/40% up to $250 per script
Home delivery pharmacy[4] (tier 1/tier 2/tier 3/tier 4)	$20/$125/$225/30% up to $250 per script	$40/$238/$375/30% up to $250 per script	$20/$175/$275/30% up to $250 per script
Dental and vision	Pediatric dental and vision covered Adult dental not covered, eye exam only covered	Pediatric dental and vision covered Adult dental not covered, eye exam only covered	Pediatric dental and vision covered Adult dental not covered, eye exam only covered

Footnotes

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◊ These plans have a different deductible amount if the subscriber is enrolled as self only or has enrolled dependents in the plan (Subscriber only/Subscriber enrolled with a Family/Family). Plans comply with AB1305 and IRS minimum deductible and out-of-pocket maximum requirements for embedded high-deductible health plans.

† After deductible has been met on this plan, medical benefits are paid at 100% and pharmacy benefits apply member copays as listed.

‡ Deductible waived for drugs on the PreventiveRx Plus drug list.

1 Primary care physician (PCP) and Specialist (SPC) cost share applies to medical office visits and virtual visits with a member's regular PCP or SPC. NOTE: The PCP cost share does not apply to virtual primary care visits for **Virtual Access Plus** and **Vivity HMO plans** which are covered in full.

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3 For plans with a deductible, the pharmacy cost share applies after deductible for the tiers as listed. For plans with a separate pharmacy deductible, the deductible is combined for retail and home delivery.

4 Home delivery program typically covers up to a 90-day supply for tier 1, tier 2 and tier 3 drugs and up to a 30-day supply for tier 4 drugs.

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Small Group EmployeeElect product details – groups of 1 to 100 employees

Anthem Vivity HMO plans

	Platinum plans	Gold plans	
Plan name	**Anthem Platinum Vivity HMO 15**	**Anthem Gold Vivity HMO 25**	**Anthem Gold Vivity HMO 25/500**
Network (contract codes)	Vivity (8ZXY)	Vivity (8ZYJ)	Vivity (8ZYZ)
In-network deductible (individual/family)	$0/$0	$0/$0	$500/$1,500
Out-of-network deductible (individual/family)	Not applicable	Not applicable	Not applicable
In-network coinsurance	None	None	None
Out-of-network coinsurance	Not applicable	Not applicable	Not applicable
In-network out-of-pocket maximum (individual/family)	$2,500/$5,000	$8,000/$16,000	$6,500/$13,000
Out-of-network out-of-pocket maximum (individual/family)	Not applicable	Not applicable	Not applicable
Office and virtual visits[1]: Primary care (PCP)/Specialist (SPC)	PCP: $15 SPC: $30	PCP: $25 SPC: $50	PCP: $25 SPC: $50
Virtual primary care and urgent/acute care services: Virtual care-only provider[2]	Covered in full	Covered in full	Covered in full
Urgent care (office)	$15	$25	$25
Emergency room (facility)	$500	$500	Deductible, then $500
Independent facility: ambulatory outpatient surgery center	$500	$500	Deductible, then $500
Hospital outpatient surgery facility	$500	$500	Deductible, then $500
Hospital inpatient admission	$500 per day up to 4 days per admission	$500 per day up to 4 days per admission	Deductible, then $500 per admission
Prescription drugs: network/drug list	Rx Choice Tiered Network with R90/ Select	Rx Choice Tiered Network with R90/ Select	Rx Choice Tiered Network with R90/ Select
Pharmacy deductible[3] (individual/family)	Tiers 1-4: No deductible	Tiers 1-4: No deductible	Tiers 1-3: No deductible Tier 4: Medical deductible applies
Retail pharmacy: 30-day supply (tier 1/tier 2/tier 3/tier 4)	Level 1: $5/$25/$75/$250 Level 2: $15/$35/$85/$250	Level 1: $10/$40/$100/$250 Level 2: $20/$50/$110/$250	Level 1: $10/$40/$100/$250 Level 2: $20/$50/$110/$250
Home delivery pharmacy[4] (tier 1/tier 2/tier 3/tier 4)	$10/$63/$188/$250	$20/$100/$250/$250	$20/$100/$250/$250
Dental and vision	Pediatric dental and vision covered Adult dental not covered, eye exam only covered	Pediatric dental and vision covered Adult dental not covered, eye exam only covered	Pediatric dental and vision covered Adult dental not covered, eye exam only covered

Footnotes

Ω Site of Service plan may have reduced cost shares for laboratory services received at an independent lab; radiology and advanced diagnostic imaging services received at an independent radiology center; and outpatient surgery received at an ambulatory surgical center.Ω

◊ These plans have a different deductible amount if the subscriber is enrolled as self only or has enrolled dependents in the plan (Subscriber only/Subscriber enrolled with a Family/Family). Plans comply with AB1305 and IRS minimum deductible and out-of-pocket maximum requirements for embedded high-deductible health plans.

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3 For plans with a deductible, the pharmacy cost share applies after deductible for the tiers as listed. For plans with a separate pharmacy deductible, the deductible is combined for retail and home delivery.

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Small Group EmployeeElect product details – groups of 1 to 100 employees

Anthem Vivity HMO plans

	Gold plans	
Plan name	**Anthem Gold Vivity HMO 35/1000**	**Anthem Gold Vivity HMO 35/1850**
Network (contract codes)	Vivity (900A)	Vivity (8ZZY)
In-network deductible (individual/family)	$1,000/$2,000	$1,850/$3,700
Out-of-network deductible (individual/family)	Not applicable	Not applicable
In-network coinsurance	None	None
Out-of-network coinsurance	Not applicable	Not applicable
In-network out-of-pocket maximum (individual/family)	$6,250/$12,500	$6,600/$13,200
Out-of-network out-of-pocket maximum (individual/family)	Not applicable	Not applicable
Office and virtual visits[1]: Primary care (PCP)/Specialist (SPC)	PCP: $35 SPC: $75	PCP: $35 SPC: $75
Virtual primary care and urgent/acute care services: Virtual care-only provider[2]	Covered in full	Covered in full
Urgent care (office)	$35	$35
Emergency room (facility)	Deductible, then $500	Deductible, then $500
Independent facility: ambulatory outpatient surgery center	Deductible, then $500	Deductible, then $500
Hospital outpatient surgery facility	Deductible, then $500	Deductible, then $500
Hospital inpatient admission	Deductible, then $750 per admission	Deductible, then $750 per admission
Prescription drugs: network/drug list	Rx Choice Tiered Network with R90/ Select	Rx Choice Tiered Network with R90/ Select
Pharmacy deductible[3] (individual/family)	Tiers 1-3: No deductible Tier 4: Medical deductible applies	Tiers 1-3: No deductible Tier 4: Medical deductible applies
Retail pharmacy: 30-day supply (tier 1/tier 2/tier 3/tier 4)	Level 1: $10/$40/$100/$250 Level 2: $20/$50/$110/$250	Level 1: $10/$40/$100/$250 Level 2: $20/$50/$110/$250
Home delivery pharmacy[4] (tier 1/tier 2/tier 3/tier 4)	$20/$100/$250/$250	$20/$100/$250/$250
Dental and vision	Pediatric dental and vision covered Adult dental not covered, eye exam only covered	Pediatric dental and vision covered Adult dental not covered, eye exam only covered

Footnotes

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◊ These plans have a different deductible amount if the subscriber is enrolled as self only or has enrolled dependents in the plan (Subscriber only/Subscriber enrolled with a Family/Family). Plans comply with AB1305 and IRS minimum deductible and out-of-pocket maximum requirements for embedded high-deductible health plans.

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‡ Deductible waived for drugs on the PreventiveRx Plus drug list.

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2 Cost share may apply to virtual visits for urgent/acute medical and behavioral health (mental health/substance use disorder) services from the virtual care only providers available through Sydney Health and our website. In addition, virtual visits for Building Healthy Families Breastfeeding Support and EAP counseling visits from our virtual care-only providers are included with all medical plans at no additional cost.

3 For plans with a deductible, the pharmacy cost share applies after deductible for the tiers as listed. For plans with a separate pharmacy deductible, the deductible is combined for retail and home delivery.

4 Home delivery program typically covers up to a 90-day supply for tier 1, tier 2 and tier 3 drugs and up to a 30-day supply for tier 4 drugs.

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Small Group EmployeeElect product details – groups of 1 to 100 employees

Anthem PPO Whole Health plans

	Platinum plans	Gold plans	
Plan name	**Anthem Platinum PPO 5/200/15% WH Ω**	**Anthem Gold PPO 35/500/25% WH Ω**	**Anthem Gold PPO 35/1000/20% WH Ω**
Network (contract codes)	Prudent Buyer PPO (8V6P)	Prudent Buyer PPO (8V5S)	Prudent Buyer PPO (8V7L)
In-network deductible (individual/family)	$200/$600	$500/$1,500	$1,000/$3,000
Out-of-network deductible (individual/family)	$2,000/$4,000	$2,000/$4,000	$2,000/$4,000
In-network coinsurance	15%	25%	20%
Out-of-network coinsurance	50%	50%	50%
In-network out-of-pocket maximum (individual/family)	$3,600/$7,200	$8,200/$16,400	$8,200/$16,400
Out-of-network out-of-pocket maximum (individual/family)	$7,200/$14,400	$16,400/$32,800	$16,400/$32,800
Office and virtual visits[1]: Primary care (PCP)/Specialist (SPC)	PCP: $5 SPC: $45	PCP: $35 SPC: $65	PCP: $35 SPC: $60
Virtual primary care and urgent/acute care services: Virtual care-only provider[2]	Covered in full	Covered in full	Covered in full
Urgent care (office)	$5	$35	$35
Emergency room (facility)	Deductible, then $250 and 15% coinsurance	Deductible, then $250 and 25% coinsurance	Deductible, then $250 and 20% coinsurance
Independent facility: ambulatory outpatient surgery center	Deductible, then $50 and 15% coinsurance	Deductible, then $50 and 25% coinsurance	Deductible, then $50 and 20% coinsurance
Hospital outpatient surgery facility	Deductible, then $250 and 15% coinsurance	Deductible, then $250 and 25% coinsurance	Deductible, then $250 and 20% coinsurance
Hospital inpatient admission	Deductible, then 15% coinsurance	Deductible, then 25% coinsurance	Deductible, then 20% coinsurance
Prescription drugs: network/drug list	Rx Choice Tiered Network with R90/ Select	Rx Choice Tiered Network with R90/ Select	Rx Choice Tiered Network with R90/ Select
Pharmacy deductible[3] (individual/family)	Tiers 1-4: No deductible	Tier 1: No deductible Tiers 2-4: $250/$500 Pharmacy deductible	Tier 1: No deductible Tiers 2-4: $300/$600 Pharmacy deductible
Retail pharmacy: 30-day supply (tier 1/tier 2/tier 3/tier 4)	Level 1: $5/$30/$50/30% up to $250 per script Level 2: $15/$40/$60/40% up to $250 per script	Level 1: $10/$50/$90/30% up to $250 per script Level 2: $20/$60/$100/40% up to $250 per script	Level 1: $5/$60/$110/30% up to $250 per script Level 2: $15/$70/$120/40% up to $250 per script
Home delivery pharmacy[4] (tier 1/tier 2/tier 3/tier 4)	$10/$75/$125/30% up to $250 per script	$20/$125/$225/30% up to $250 per script	$10/$150/$275/30% up to $250 per script
Dental and vision	Enhanced pediatric dental and vision covered Adult dental and vision covered	Enhanced pediatric dental and vision covered Adult dental and vision covered	Enhanced pediatric dental and vision covered Adult dental and vision covered

Footnotes

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‡ Deductible waived for drugs on the PreventiveRx Plus drug list.

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Small Group EmployeeElect product details – groups of 1 to 100 employees

Anthem PPO Whole Health plans

	Silver plans	
Plan name	**Anthem Silver PPO 45/1750/40% WH Ω**	**Anthem Silver PPO 55/2500/45% WH Ω**
Network (contract codes)	Prudent Buyer PPO (8V8M) Select PPO (8V8L)	Prudent Buyer PPO (8VA6)
In-network deductible (individual/family)	$1,750/$3,500	$2,500/$5,000
Out-of-network deductible (individual/family)	$3,500/$7,000	$5,000/$10,000
In-network coinsurance	40%	45%
Out-of-network coinsurance	50%	50%
In-network out-of-pocket maximum (individual/family)	$9,100/$18,200	$8,700/$17,400
Out-of-network out-of-pocket maximum (individual/family)	$18,200/$36,400	$17,400/$34,800
Office and virtual visits[1]: Primary care (PCP)/Specialist (SPC)	PCP: $45 SPC: $95	PCP: $55 SPC: $90
Virtual primary care and urgent/acute care services: Virtual care-only provider[2]	Covered in full	Covered in full
Urgent care (office)	$45	$55
Emergency room (facility)	Deductible, then $300 and 40% coinsurance	Deductible, then $100 and 45% coinsurance
Independent facility: ambulatory outpatient surgery center	Deductible, then $50 and 40% coinsurance	Deductible, then $50 and 45% coinsurance
Hospital outpatient surgery facility	Deductible, then $300 and 40% coinsurance	Deductible, then $250 and 45% coinsurance
Hospital inpatient admission	Deductible, then 40% coinsurance	Deductible, then 45% coinsurance
Prescription drugs: network/drug list	Rx Choice Tiered Network with R90/ Select	Rx Choice Tiered Network with R90/ Select
Pharmacy deductible[3] (individual/family)	Tier 1: No deductible Tiers 2-4: $300/$600 Pharmacy deductible	Tier 1: No deductible Tiers 2-4: $200/$400 Pharmacy deductible
Retail pharmacy: 30-day supply (tier 1/tier 2/tier 3/tier 4)	Level 1: $15/$70/$110/30% up to $250 per script Level 2: $20/$80/$120/40% up to $250 per script	Level 1: $15/$70/$110/30% up to $250 per script Level 2: $20/$80/$120/40% up to $250 per script
Home delivery pharmacy[4] (tier 1/tier 2/tier 3/tier 4)	$30/$175/$275/30% up to $250 per script	$30/$175/$275/30% up to $250 per script
Dental and vision	Enhanced pediatric dental and vision covered Adult dental and vision covered	Enhanced pediatric dental and vision covered Adult dental and vision covered

Footnotes

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◊ These plans have a different deductible amount if the subscriber is enrolled as self only or has enrolled dependents in the plan (Subscriber only/Subscriber enrolled with a Family/Family). Plans comply with AB1305 and IRS minimum deductible and out-of-pocket maximum requirements for embedded high-deductible health plans.

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1 Primary care physician (PCP) and Specialist (SPC) cost share applies to medical office visits and virtual visits with a member's regular PCP or SPC. NOTE: The PCP cost share does not apply to virtual primary care visits for **Virtual Access Plus** and **Vivity HMO plans** which are covered in full.

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Small Group EmployeeElect product details – groups of 1 to 100 employees

Anthem PPO HSA Whole Health plans

	Bronze plans	
Plan name	**Anthem Bronze PPO 6000/45% w/HSA PrevRx WH Ω**	**Anthem Bronze PPO 6700/0% w/HSA PrevRx WH**
Network (contract codes)	Prudent Buyer PPO (8VDZ)	Prudent Buyer PPO (8VEE)
In-network deductible (individual/family)	$6,000/$12,000	$6,700/$13,400
Out-of-network deductible (individual/family)	$12,000/$24,000	$13,400/$26,800
In-network coinsurance	45%	0%
Out-of-network coinsurance	50%	50%
In-network out-of-pocket maximum (individual/family)	$7,400/$14,800	$7,800/$15,600
Out-of-network out-of-pocket maximum (individual/family)	$14,800/$29,600	$15,600/$31,200
Office and virtual visits[1]: Primary care (PCP)/Specialist (SPC)	Deductible, then 45% coinsurance	Deductible, then 0% coinsurance
Virtual primary care and urgent/acute care services: Virtual care-only provider[2]	Deductible, then covered in full	Deductible, then covered in full
Urgent care (office)	Deductible, then 45% coinsurance	Deductible, then 0% coinsurance
Emergency room (facility)	Deductible, then 45% coinsurance	Deductible, then 0% coinsurance
Independent facility: ambulatory outpatient surgery center	Deductible, then $50 and 45% coinsurance	Deductible, then 0% coinsurance
Hospital outpatient surgery facility	Deductible, then $250 and 45% coinsurance	Deductible, then 0% coinsurance
Hospital inpatient admission	Deductible, then 45% coinsurance	Deductible, then 0% coinsurance
Prescription drugs: network/drug list	Rx Choice Tiered Network with R90/ Select	Rx Choice Tiered Network with R90/ Select
Pharmacy deductible[3] (individual/family)	Tiers 1-4: Medical deductible applies ‡	Tiers 1-4: Medical deductible applies ‡
Retail pharmacy: 30-day supply (tier 1/tier 2/tier 3/tier 4)	Level 1: $20/$90/$160/30% up to $400 per script Level 2: $20/$100/$170/40% up to $500 per script	Level 1: $20/$90/$160/30% up to $400 per script Level 2: $20/$100/$170/40% up to $500 per script
Home delivery pharmacy[4] (tier 1/tier 2/tier 3/tier 4)	$40/$225/$400/30% up to $400 per script	$40/$225/$400/30% up to $400 per script
Dental and vision	Enhanced pediatric dental and vision covered Adult dental and vision covered	Enhanced pediatric dental and vision covered Adult dental and vision covered

Footnotes

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◊ These plans have a different deductible amount if the subscriber is enrolled as self only or has enrolled dependents in the plan (Subscriber only/Subscriber enrolled with a Family/Family). Plans comply with AB1305 and IRS minimum deductible and out-of-pocket maximum requirements for embedded high-deductible health plans.

† After deductible has been met on this plan, medical benefits are paid at 100% and pharmacy benefits apply member copays as listed.

‡ Deductible waived for drugs on the PreventiveRx Plus drug list.

1 Primary care physician (PCP) and Specialist (SPC) cost share applies to medical office visits and virtual visits with a member's regular PCP or SPC. NOTE: The PCP cost share does not apply to virtual primary care visits for **Virtual Access Plus** and **Vivity HMO plans** which are covered in full.

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Small Group EmployeeElect product details – groups of 1 to 100 employees

Anthem HMO Whole Health plans

	Silver plans
Plan name	**Anthem Silver Select HMO 60/2500/45% WH Ω**
Network (contract codes)	Select HMO (94KH)
In-network deductible (individual/family)	$2,500/$5,000
Out-of-network deductible (individual/family)	Not applicable
In-network coinsurance	45%
Out-of-network coinsurance	Not applicable
In-network out-of-pocket maximum (individual/family)	$10,150/$20,300
Out-of-network out-of-pocket maximum (individual/family)	Not applicable
Office and virtual visits[1]: Primary care (PCP)/Specialist (SPC)	PCP: $60 SPC: $95
Virtual primary care and urgent/acute care services: Virtual care-only provider[2]	Covered in full
Urgent care (office)	$60
Emergency room (facility)	Deductible, then $500 and 45% coinsurance
Independent facility: ambulatory outpatient surgery center	Deductible, then $600
Hospital outpatient surgery facility	Deductible, then 45% coinsurance
Hospital inpatient admission	Deductible, then 45% coinsurance
Prescription drugs: network/drug list	Rx Choice Tiered Network with R90/ Select
Pharmacy deductible[3] (individual/family)	Tier 1: No deductible Tiers 2-4: $200/$400 Pharmacy deductible
Retail pharmacy: 30-day supply (tier 1/tier 2/tier 3/tier 4)	Level 1: $10/$70/$110/30% up to $250 per script Level 2: $20/$80/$120/40% up to $250 per script
Home delivery pharmacy[4] (tier 1/tier 2/tier 3/tier 4)	$20/$175/$275/30% up to $250 per script
Dental and vision	Enhanced pediatric dental and vision covered Adult dental and vision covered

Footnotes

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◊ These plans have a different deductible amount if the subscriber is enrolled as self only or has enrolled dependents in the plan (Subscriber only/Subscriber enrolled with a Family/Family). Plans comply with AB1305 and IRS minimum deductible and out-of-pocket maximum requirements for embedded high-deductible health plans.

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Small Group EmployeeElect product details – groups of 1 to 100 employees

Anthem Vivity HMO Whole Health plans

	Platinum plans	Gold plans	
Plan name	**Anthem Platinum Vivity HMO 15 WH**	**Anthem Gold Vivity HMO 25 WH**	**Anthem Gold Vivity HMO 25/500 WH**
Network (contract codes)	Vivity (8ZY5)	Vivity (8ZYH)	Vivity (8ZYX)
In-network deductible (individual/family)	$0/$0	$0/$0	$500/$1,500
Out-of-network deductible (individual/family)	Not applicable	Not applicable	Not applicable
In-network coinsurance	None	None	None
Out-of-network coinsurance	Not applicable	Not applicable	Not applicable
In-network out-of-pocket maximum (individual/family)	$2,500/$5,000	$8,000/$16,000	$6,500/$13,000
Out-of-network out-of-pocket maximum (individual/family)	Not applicable	Not applicable	Not applicable
Office and virtual visits[1]: Primary care (PCP)/Specialist (SPC)	PCP: $15 SPC: $30	PCP: $25 SPC: $50	PCP: $25 SPC: $50
Virtual primary care and urgent/acute care services: Virtual care-only provider[2]	Covered in full	Covered in full	Covered in full
Urgent care (office)	$15	$25	$25
Emergency room (facility)	$500	$500	Deductible, then $500
Independent facility: ambulatory outpatient surgery center	$500	$500	Deductible, then $500
Hospital outpatient surgery facility	$500	$500	Deductible, then $500
Hospital inpatient admission	$500 per day up to 4 days per admission	$500 per day up to 4 days per admission	Deductible, then $500 per admission
Prescription drugs: network/drug list	Rx Choice Tiered Network with R90/ Select	Rx Choice Tiered Network with R90/ Select	Rx Choice Tiered Network with R90/ Select
Pharmacy deductible[3] (individual/family)	Tiers 1-4: No deductible	Tiers 1-4: No deductible	Tiers 1-3: No deductible Tier 4: Medical deductible applies
Retail pharmacy: 30-day supply (tier 1/tier 2/tier 3/tier 4)	Level 1: $5/$25/$75/$250 Level 2: $15/$35/$85/$250	Level 1: $10/$40/$100/$250 Level 2: $20/$50/$110/$250	Level 1: $10/$40/$100/$250 Level 2: $20/$50/$110/$250
Home delivery pharmacy[4] (tier 1/tier 2/tier 3/tier 4)	$10/$63/$188/$250	$20/$100/$250/$250	$20/$100/$250/$250
Dental and vision	Enhanced pediatric dental and vision covered Adult dental and vision covered	Enhanced pediatric dental and vision covered Adult dental and vision covered	Enhanced pediatric dental and vision covered Adult dental and vision covered

Footnotes

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Anthem Vivity HMO Whole Health plans

	Gold plans	
Plan name	**Anthem Gold Vivity HMO 35/1000 WH**	**Anthem Gold Vivity HMO 35/1850 WH**
Network (contract codes)	Vivity (8ZZX)	Vivity (8ZZZ)
In-network deductible (individual/family)	$1,000/$2,000	$1,850/$3,700
Out-of-network deductible (individual/family)	Not applicable	Not applicable
In-network coinsurance	None	None
Out-of-network coinsurance	Not applicable	Not applicable
In-network out-of-pocket maximum (individual/family)	$6,250/$12,500	$6,600/$13,200
Out-of-network out-of-pocket maximum (individual/family)	Not applicable	Not applicable
Office and virtual visits[1]: Primary care (PCP)/Specialist (SPC)	PCP: $35 SPC: $75	PCP: $35 SPC: $75
Virtual primary care and urgent/acute care services: Virtual care-only provider[2]	Covered in full	Covered in full
Urgent care (office)	$35	$35
Emergency room (facility)	Deductible, then $500	Deductible, then $500
Independent facility: ambulatory outpatient surgery center	Deductible, then $500	Deductible, then $500
Hospital outpatient surgery facility	Deductible, then $500	Deductible, then $500
Hospital inpatient admission	Deductible, then $750 per admission	Deductible, then $750 per admission
Prescription drugs: network/drug list	Rx Choice Tiered Network with R90/ Select	Rx Choice Tiered Network with R90/ Select
Pharmacy deductible[3] (individual/family)	Tiers 1-3: No deductible Tier 4: Medical deductible applies	Tiers 1-3: No deductible Tier 4: Medical deductible applies
Retail pharmacy: 30-day supply (tier 1/tier 2/tier 3/tier 4)	Level 1: $10/$40/$100/$250 Level 2: $20/$50/$110/$250	Level 1: $10/$40/$100/$250 Level 2: $20/$50/$110/$250
Home delivery pharmacy[4] (tier 1/tier 2/tier 3/tier 4)	$20/$100/$250/$250	$20/$100/$250/$250
Dental and vision	Enhanced pediatric dental and vision covered Adult dental and vision covered	Enhanced pediatric dental and vision covered Adult dental and vision covered

Footnotes

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3 For plans with a deductible, the pharmacy cost share applies after deductible for the tiers as listed. For plans with a separate pharmacy deductible, the deductible is combined for retail and home delivery.

4 Home delivery program typically covers up to a 90-day supply for tier 1, tier 2 and tier 3 drugs and up to a 30-day supply for tier 4 drugs.

This is intended to be a brief overview of plans/benefits and is not intended to be a legal contract. The entire provisions of benefits, limitations and exclusions can be found in the Combined Evidence of Coverage/Certificate. In the event of a conflict between the Combined Evidence of Coverage/Certificate and this overview, the terms of the Combined Evidence of Coverage/Certificate will prevail.

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Thank you for the opportunity to be your trusted partner in health. We understand providing benefits is an important decision for small businesses. That's why we are committed to earning your confidence by offering transformative solutions to help simplify care, improve access and affordability, and achieve better health for your employees and their families.

By always asking more of ourselves, we strive to build and deliver the healthcare of tomorrow for your employees, right now. We look forward to collaborating to elevate the health of your employees and your business.

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