# California

Effective January 1, 2027

Anthem

# Medical

## Benefit charts

2027 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.

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**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.

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**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 1-100 employees

***NEW* for 2027**

**First-Dollar Coverage for Virtual Care on HSA compatible plans**

- Per the IRS Telehealth Safe Harbor, deductible will no longer apply to virtual primary care, urgent/acute care and mental health/substance use disorder visits rendered by our virtual care-only providers through Sydney Health.

**First-Dollar Copay now applies to Mental Health visits on select Bronze PPO plans**

- Cost share is changing from deductible, then coinsurance to a flat dollar copay with deductible waived
- Visits include outpatient mental health/substance abuse disorders and nutritional counseling visits in a virtual or office visit setting
- Plans impacted Anthem Bronze PPO 40/6200/40%, Anthem Bronze PPO 70/6600/35%, and Anthem Bronze PPO 60/6850/40% (also applies to Select PPO plans)

**Lab/Xray benefit changes:**

- Streamlining member copays to one copay per provider per visit for multiple services
- Copay cost share changes on certain PPO and HMO plans

**Rx for Infusion/Injection benefit changes:**

- Streamlining member copays to one copay per provider per visit for multiple services

**SHOP Mirror plans**

- SHOP Mirror plans now include "Mirror" at the end of the plan name

***The Small Group portfolio includes:***

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.

Dental and vision benefits:

- Pediatric dental, pediatric vision and adult eye exams are covered with all Small Group plans.

Employee Assistance Program (EAP) / Wellness:

- All of our plans include an Employee Assistance Program that offers a wide range of work and life support services.

Virtual Care:

- Virtual primary care visits with the virtual care-only providers available through Sydney Health and our website covered in full (no cost share) on all plans.

Pharmacy features to partner with CarelonRx:

- Rx Choice Tiered Pharmacy Network with R90 features lower cost shares for preferred pharmacies, greater flexibility, access and convenience with expanded pharmacies
- PreventiveRx Plus on HSA plans with "Prev Rx" in plan name waives the deductible on certain Tier 1 and Tier 2 preventive medications to treat conditions including heart health, high blood pressure, osteoporosis, asthma, diabetes, mental health and high cholesterol
- All plans use the Select Drug List
- CarelonRx Home Delivery featuring reduced mail order cost shares to be less than retail to maximize cost savings and convenience of using our CarelonRx Pharmacy

# Small Group EmployeeElect product details – groups of 1-100 employees

***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 1-100 employees

## Anthem Virtual Access Plus PPO plans

| | Platinum plans | Gold plans | |
|---|---|---|---|
| **Plan name** | **Anthem Virtual Access Plus Platinum PPO 20 Ω** | **Anthem Virtual Access Plus Gold PPO 30 Ω** | **Anthem Virtual Access Plus Gold PPO 25/1000 Ω** |
| Network (contract codes) | Prudent Buyer PPO (1GRJ)<br>Select PPO (1GKN) | Prudent Buyer PPO (1GPE)<br>Select PPO (1GQX) | Prudent Buyer PPO (1GQD)<br>Select PPO (1GQF) |
| In-network deductible (individual/family) | $0/$0 | $0/$0 | $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 | None | None | None |
| Out-of-network coinsurance | 50% | 50% | 50% |
| In-network out-of-pocket maximum (individual/family) | $3,600/$7,200 | $11,600/$23,200 | $5,700/$11,400 |
| Out-of-network out-of-pocket maximum (individual/family) | $7,200/$14,400 | $23,200/$46,400 | $11,400/$22,800 |
| Office and virtual visits[1]: Primary care (PCP)/ Specialist (SPC) | PCP: $20<br>SPC: $40 | PCP: $30<br>SPC: $60 | PCP: $25<br>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 | $30 | $25 |
| Emergency room (facility) | $250 | $500 | Deductible, then $350 |
| Independent facility: ambulatory outpatient surgery center | $75 | $250 | $250 |
| Hospital outpatient surgery facility | $150 | $250 | Deductible, then $250 |
| 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<br>Tier 4: Medical deductible applies |
| Retail pharmacy: 30-day supply (tier 1/tier 2/tier 3/tier 4) | Level 1: $5/$25/$75/$250<br>Level 2: $15/$35/$85/$250 | Level 1: $10/$35/$75/$250<br>Level 2: $20/$45/$85/$250 | Level 1: $10/$40/$100/$250<br>Level 2: $20/$50/$110/$250 |
| Home delivery pharmacy[4] (tier 1/tier 2/tier 3/tier 4) | $10/$63/$188/$250 | $20/$88/$188/$250 | $20/$100/$250/$250 |
| Dental and vision | Pediatric dental and vision covered<br>Adult dental not covered, eye exam only covered | Pediatric dental and vision covered<br>Adult dental not covered, eye exam only covered | Pediatric dental and vision covered<br>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.

◊ 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 drug tiers 1-3 and up to a 30-day supply for drug tier 4 (Specialty 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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# Small Group EmployeeElect product details – groups of 1-100 employees

## Anthem Virtual Access Plus PPO plans

| | Gold plans | Silver plans |
|---|---|---|
| **Plan name** | **Anthem Virtual Access Plus Gold PPO 10/1500 Ω** | **Anthem Virtual Access Plus Silver PPO 50/3200 Ω** |
| Network (contract codes) | Prudent Buyer PPO (1GQE)<br>Select PPO (1GHD) | Prudent Buyer PPO (1GR0)<br>Select PPO (1GRM) |
| In-network deductible (individual/family) | $1,500/$4,500 | $3,200/$6,400 |
| Out-of-network deductible (individual/family) | $3,000/$6,000 | $6,400/$12,800 |
| In-network coinsurance | None | None |
| Out-of-network coinsurance | 50% | 50% |
| In-network out-of-pocket maximum (individual/family) | $7,000/$14,000 | $10,150/$20,300 |
| Out-of-network out-of-pocket maximum (individual/family) | $14,000/$28,000 | $20,300/$40,600 |
| Office and virtual visits[1]: Primary care (PCP)/ Specialist (SPC) | PCP: $10<br>SPC: $60 | PCP: $50<br>SPC: $90 |
| Virtual primary care and urgent/acute care services: Virtual care-only provider[2] | Covered in full | Covered in full |
| Urgent care (office) | $10 | $50 |
| Emergency room (facility) | Deductible, then $500 | Deductible, then $500 |
| Independent facility: ambulatory outpatient surgery center | $250 | $250 |
| Hospital outpatient surgery facility | Deductible, then $100 | 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<br>Tier 4: Medical deductible applies | Tiers 1-3: No deductible<br>Tier 4: Medical deductible applies |
| Retail pharmacy: 30-day supply (tier 1/tier 2/tier 3/tier 4) | Level 1: $10/$40/$100/$250<br>Level 2: $20/$50/$110/$250 | Level 1: $10/$40/$100/$250<br>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<br>Adult dental not covered, eye exam only covered | Pediatric dental and vision covered<br>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.

◊ 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 1-100 employees

## Anthem PPO plans

| | Platinum plans | | |
|---|---|---|---|
| **Plan name** | **Anthem Platinum PPO 15/40/10% Ω** | **Anthem Platinum PPO 5/200/15% Ω** | **Anthem Platinum PPO 15/250/10% Ω** |
| Network (contract codes) | Prudent Buyer PPO (1GR8)<br>Select PPO (1GS8) | Prudent Buyer PPO (1GKJ)<br>Select PPO (1GQV) | Prudent Buyer PPO (1GRV)<br>Select PPO (1G9M) |
| In-network deductible (individual/family) | $0/$0 | $200/$600 | $250/$750 |
| Out-of-network deductible (individual/family) | $2,000/$4,000 | $2,000/$4,000 | $2,000/$4,000 |
| In-network coinsurance | 10% | 15% | 10% |
| Out-of-network coinsurance | 50% | 50% | 50% |
| In-network out-of-pocket maximum (individual/family) | $4,800/$9,600 | $4,000/$8,000 | $4,400/$8,800 |
| Out-of-network out-of-pocket maximum (individual/family) | $9,600/$19,200 | $8,000/$16,000 | $8,800/$17,600 |
| Office and virtual visits[1]: Primary care (PCP)/ Specialist (SPC) | PCP: $15<br>SPC: $40 | PCP: $5<br>SPC: $45 | PCP: $15<br>SPC: $30 |
| 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 | $5 | $15 |
| Emergency room (facility) | $350, then 10% coinsurance | Deductible, then $250 and 15% coinsurance | Deductible, then $225 and 10% coinsurance |
| Independent facility: ambulatory outpatient surgery center | $100, then 10% coinsurance | Deductible, then $50 and 15% coinsurance | Deductible, then $50 and 10% coinsurance |
| Hospital outpatient surgery facility | $200, then 10% coinsurance | Deductible, then $250 and 15% coinsurance | Deductible, then $250 and 10% coinsurance |
| Hospital inpatient admission | 10% coinsurance | Deductible, then 15% coinsurance | Deductible, then 10% 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/$35/$55/30% up to $250 per script<br>Level 2: $15/$50/$65/40% up to $250 per script | Level 1: $5/$30/$50/30% up to $250 per script<br>Level 2: $15/$40/$60/40% up to $250 per script | Level 1: $5/$30/$50/30% up to $250 per script<br>Level 2: $15/$40/$60/40% up to $250 per script |
| Home delivery pharmacy[4] (tier 1/tier 2/tier 3/tier 4) | $20/$88/$138/30% 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<br>Adult dental not covered, eye exam only covered | Pediatric dental and vision covered<br>Adult dental not covered, eye exam only covered | Pediatric dental and vision covered<br>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.

◊ 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 1-100 employees

## Anthem PPO plans

| | Gold plans | | |
|---|---|---|---|
| **Plan name** | **Anthem Gold PPO 25/30% Ω** | **Anthem Gold PPO 30/500/20% Ω** | **Anthem Gold PPO 35/500/25% Ω** |
| Network (contract codes) | Prudent Buyer PPO (1GS2)<br>Select PPO (130M) | Prudent Buyer PPO (12YQ)<br>Select PPO (12N3) | Prudent Buyer PPO (1GGP)<br>Select PPO (1GS6) |
| In-network deductible (individual/family) | $0/$0 | $500/$1,500 | $500/$1,500 |
| Out-of-network deductible (individual/family) | $2,000/$4,000 | $2,000/$4,000 | $2,000/$4,000 |
| In-network coinsurance | 30% | 20% | 25% |
| Out-of-network coinsurance | 50% | 50% | 50% |
| In-network out-of-pocket maximum (individual/family) | $10,500/$21,000 | $9,000/$18,000 | $8,200/$16,400 |
| Out-of-network out-of-pocket maximum (individual/family) | $21,000/$42,000 | $18,000/$36,000 | $16,400/$32,800 |
| Office and virtual visits[1]: Primary care (PCP)/ Specialist (SPC) | PCP: $25<br>SPC: $50 | PCP: $30<br>SPC: $60 | PCP: $35<br>SPC: $65 |
| 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) | $25 | $30 | $35 |
| Emergency room (facility) | $500, then 30% coinsurance | Deductible, then $400 and 20% coinsurance | Deductible, then $250 and 25% coinsurance |
| Independent facility: ambulatory outpatient surgery center | $150, then 30% coinsurance | Deductible, then $100 and 20% coinsurance | Deductible, then $50 and 25% coinsurance |
| Hospital outpatient surgery facility | $300, then 30% coinsurance | Deductible, then $250 and 20% coinsurance | Deductible, then $250 and 25% coinsurance |
| Hospital inpatient admission | 30% coinsurance | Deductible, then 20% coinsurance | Deductible, then 25% 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 | Tier 1: No deductible<br>Tiers 2-4: $250/$500 Pharmacy deductible |
| Retail pharmacy: 30-day supply (tier 1/tier 2/tier 3/tier 4) | Level 1: $20/$50/$90/30% up to $250 per script<br>Level 2: $30/$60/$100/40% up to $250 per script | Level 1: $10/$50/$90/30% up to $250 per script<br>Level 2: $20/$60/$100/40% up to $250 per script | Level 1: $10/$50/$90/30% up to $250 per script<br>Level 2: $20/$60/$100/40% up to $250 per script |
| Home delivery pharmacy[4] (tier 1/tier 2/tier 3/tier 4) | $40/$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<br>Adult dental not covered, eye exam only covered | Pediatric dental and vision covered<br>Adult dental not covered, eye exam only covered | Pediatric dental and vision covered<br>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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# Small Group EmployeeElect product details – groups of 1-100 employees

## Anthem PPO plans

| | Gold plans | | |
|---|---|---|---|
| **Plan name** | **Anthem Gold PPO 30/750/20% Ω** | **Anthem Gold PPO 35/1000/20% Ω** | **Anthem Gold PPO 5/1500/30% Ω** |
| Network (contract codes) | Prudent Buyer PPO (1GR5)<br>Select PPO (1300) | Prudent Buyer PPO (1GGF)<br>Select PPO (1G9P) | Prudent Buyer PPO (12ZT)<br>Select PPO (12YN) |
| In-network deductible (individual/family) | $750/$2,250 | $1,000/$3,000 | $1,500/$3,000 |
| Out-of-network deductible (individual/family) | $2,000/$4,000 | $2,000/$4,000 | $3,000/$6,000 |
| In-network coinsurance | 20% | 20% | 30% |
| Out-of-network coinsurance | 50% | 50% | 50% |
| In-network out-of-pocket maximum (individual/family) | $8,200/$16,400 | $8,200/$16,400 | $8,100/$16,200 |
| Out-of-network out-of-pocket maximum (individual/family) | $16,400/$32,800 | $16,400/$32,800 | $16,200/$32,400 |
| Office and virtual visits[1]: Primary care (PCP)/ Specialist (SPC) | PCP: $30<br>SPC: $55 | PCP: $35<br>SPC: $60 | PCP: $5<br>SPC: $65 |
| 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 | $5 |
| Emergency room (facility) | Deductible, then $250 and 20% coinsurance | Deductible, then $250 and 20% coinsurance | Deductible, then $250 and 30% coinsurance |
| Independent facility: ambulatory outpatient surgery center | Deductible, then $50 and 20% coinsurance | Deductible, then $50 and 20% coinsurance | Deductible, then $50 and 30% coinsurance |
| Hospital outpatient surgery facility | Deductible, then $250 and 20% coinsurance | Deductible, then $250 and 20% coinsurance | Deductible, then $250 and 30% coinsurance |
| Hospital inpatient admission | Deductible, then 20% coinsurance | Deductible, then 20% 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) | Tier 1: No deductible<br>Tiers 2-4: $250/$500 Pharmacy deductible | Tier 1: No deductible<br>Tiers 2-4: $300/$600 Pharmacy deductible | Tier 1: No deductible<br>Tiers 2-4: $300/$600 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<br>Level 2: $20/$60/$100/40% up to $250 per script | Level 1: $5/$60/$110/30% up to $250 per script<br>Level 2: $15/$70/$120/40% up to $250 per script | Level 1: $5/$60/$110/30% up to $250 per script<br>Level 2: $15/$70/$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 | $10/$150/$275/30% up to $250 per script | $10/$150/$275/30% up to $250 per script |
| Dental and vision | Pediatric dental and vision covered<br>Adult dental not covered, eye exam only covered | Pediatric dental and vision covered<br>Adult dental not covered, eye exam only covered | Pediatric dental and vision covered<br>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.

◊ 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 1-100 employees

## Anthem PPO plans

| | Silver plans | | |
|---|---|---|---|
| **Plan name** | **Anthem Silver PPO 45/1750/40% Ω** | **Anthem Silver PPO 55/1950/35% Ω** | **Anthem Silver PPO 50/2200/40% Ω** |
| Network (contract codes) | Prudent Buyer PPO (1GRE)<br>Select PPO (12N7) | Prudent Buyer PPO (130N)<br>Select PPO (1G9H) | Prudent Buyer PPO (1GQY)<br>Select PPO (1GRG) |
| In-network deductible (individual/family) | $1,750/$3,500 | $1,950/$3,900 | $2,200/$4,400 |
| Out-of-network deductible (individual/family) | $3,500/$7,000 | $3,900/$7,800 | $4,400/$8,800 |
| In-network coinsurance | 40% | 35% | 40% |
| Out-of-network coinsurance | 50% | 50% | 50% |
| In-network out-of-pocket maximum (individual/family) | $10,550/$21,100 | $10,600/$21,200 | $10,100/$20,200 |
| Out-of-network out-of-pocket maximum (individual/family) | $21,100/$42,200 | $21,200/$42,400 | $20,200/$40,400 |
| Office and virtual visits[1]: Primary care (PCP)/ Specialist (SPC) | PCP: $45<br>SPC: $95 | PCP: $55<br>SPC: $90 | PCP: $50<br>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) | $45 | $55 | $50 |
| Emergency room (facility) | Deductible, then $500 and 40% coinsurance | Deductible, then $350 and 35% coinsurance | Deductible, then $350 and 40% coinsurance |
| Independent facility: ambulatory outpatient surgery center | Deductible, then $150 and 40% coinsurance | Deductible, then $50 and 35% coinsurance | Deductible, then $50 and 40% coinsurance |
| Hospital outpatient surgery facility | Deductible, then $300 and 40% coinsurance | Deductible, then $250 and 35% coinsurance | Deductible, then $250 and 40% coinsurance |
| Hospital inpatient admission | Deductible, then 40% coinsurance | Deductible, then 35% 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<br>Tiers 2-4: $300/$600 Pharmacy deductible | Tier 1: No deductible<br>Tiers 2-4: $300/$600 Pharmacy deductible | Tier 1: No deductible<br>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<br>Level 2: $20/$80/$120/40% up to $250 per script | Level 1: $15/$70/$110/30% up to $250 per script<br>Level 2: $20/$80/$120/40% up to $250 per script | Level 1: $15/$70/$110/30% up to $250 per script<br>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<br>Adult dental not covered, eye exam only covered | Pediatric dental and vision covered<br>Adult dental not covered, eye exam only covered | Pediatric dental and vision covered<br>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.

◊ 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 1-100 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 (1GSB)<br>Select PPO (1GGE) | Prudent Buyer PPO (12N5)<br>Select PPO (1GSH) | Prudent Buyer PPO (1GRP)<br>Select PPO (1GRX) |
| 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) | $9,500/$19,000 | $9,100/$18,200 | $9,100/$18,200 |
| Out-of-network out-of-pocket maximum (individual/family) | $19,000/$38,000 | $18,200/$36,400 | $18,200/$36,400 |
| Office and virtual visits[1]: Primary care (PCP)/ Specialist (SPC) | PCP: $55<br>SPC: $90 | Deductible, then 50% coinsurance | PCP: Deductible, then $40<br>SPC: Deductible, then $80 |
| 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 | 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<br>Tiers 2-4: $200/$400 Pharmacy deductible | Tier 1: No deductible<br>Tiers 2-4: Medical deductible applies | Tier 1: No deductible<br>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<br>Level 2: $20/$80/$120/40% up to $250 per script | Level 1: $20/$80/$120/30% up to $400 per script<br>Level 2: $20/$90/$130/40% up to $500 per script | Level 1: $20/$80/$120/30% up to $400 per script<br>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<br>Adult dental not covered, eye exam only covered | Pediatric dental and vision covered<br>Adult dental not covered, eye exam only covered | Pediatric dental and vision covered<br>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.

◊ 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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# Small Group EmployeeElect product details – groups of 1-100 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 (1GKL)<br>Select PPO (12YM) | Prudent Buyer PPO (1GS5)<br>Select PPO (1GKH) | Prudent Buyer PPO (1GR7)<br>Select PPO (130J) |
| 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 | $9,100/$18,200 | $10,750/$21,500 |
| Out-of-network out-of-pocket maximum (individual/family) | $17,800/$35,600 | $18,200/$36,400 | $21,500/$43,000 |
| Office and virtual visits[1]: Primary care (PCP)/ Specialist (SPC) | PCP: Deductible, then $70<br>SPC: Deductible, then $85 | PCP: Deductible, then $60<br>SPC: Deductible, then $80 | PCP: $75<br>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<br>Tiers 2-4: Medical deductible applies | Tier 1: No deductible<br>Tiers 2-4: $650/$1,300 Pharmacy deductible | Tier 1: No deductible<br>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<br>Level 2: $20/$90/$130/40% up to $500 per script | Level 1: $20/$90/$160/30% up to $400 per script<br>Level 2: $20/$100/$170/40% up to $500 per script | Level 1: $20/$90/$160/30% up to $400 per script<br>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<br>Adult dental not covered, eye exam only covered | Pediatric dental and vision covered<br>Adult dental not covered, eye exam only covered | Pediatric dental and vision covered<br>Adult dental not covered, eye exam only covered |

### Footnotes

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# Small Group EmployeeElect product details – groups of 1-100 employees

## Anthem PPO HSA plans

| | Gold plans | Silver plans | |
|---|---|---|---|
| **Plan name** | **Anthem Gold PPO HSA/H 1900/3500/3800 15% PrevRx Ω,◊** | **Anthem Silver PPO HSA/H 2600/3500/5200 35% PrevRx Ω,◊** | **Anthem Silver PPO HSA/H 2900/3500/5800 30% PrevRx Ω,◊** |
| Network (contract codes) | Prudent Buyer PPO (130P/1GR4)<br>Select PPO (12ZY/1GQC) | Prudent Buyer PPO (1GQG/1GRS)<br>Select PPO (1GSA/1GQW) | Prudent Buyer PPO (1GSE/1GRZ)<br>Select PPO (1GQL/1GGQ) |
| In-network deductible (individual/family) | $1,900/$3,500/$3,800 | $2,600/$3,500/$5,200 | $2,900/$3,500/$5,800 |
| Out-of-network deductible (individual/family) | $3,800/$7,000/$7,600 | $5,200/$7,000/$10,400 | $5,800/$7,000/$11,600 |
| In-network coinsurance | 15% | 35% | 30% |
| Out-of-network coinsurance | 50% | 50% | 50% |
| In-network out-of-pocket maximum (individual/family) | $5,000/$10,000 | $8,700/$17,400 | $8,700/$17,400 |
| Out-of-network out-of-pocket maximum (individual/family) | $10,000/$20,000 | $17,400/$34,800 | $17,400/$34,800 |
| Office and virtual visits[1]: Primary care (PCP)/ Specialist (SPC) | Deductible, then 15% coinsurance | Deductible, then 35% coinsurance | Deductible, then 30% coinsurance |
| 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 15% coinsurance | Deductible, then 35% coinsurance | Deductible, then 30% coinsurance |
| Emergency room (facility) | Deductible, then 15% coinsurance | Deductible, then 35% coinsurance | Deductible, then 30% coinsurance |
| Independent facility: ambulatory outpatient surgery center | Deductible, then $50 and 15% coinsurance | Deductible, then $50 and 35% coinsurance | Deductible, then $50 and 30% coinsurance |
| Hospital outpatient surgery facility | Deductible, then $250 and 15% coinsurance | Deductible, then $250 and 35% coinsurance | Deductible, then $250 and 30% coinsurance |
| Hospital inpatient admission | Deductible, then 15% coinsurance | Deductible, then 35% 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<br>Level 2: $20/$40/$60/40% up to $250 per script | Level 1: $15/$70/$110/30% up to $250 per script<br>Level 2: $20/$80/$120/40% up to $250 per script | Level 1: $15/$70/$110/30% up to $250 per script<br>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 | $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<br>Adult dental not covered, eye exam only covered | Pediatric dental and vision covered<br>Adult dental not covered, eye exam only covered | Pediatric dental and vision covered<br>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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# Small Group EmployeeElect product details – groups of 1-100 employees

## Anthem PPO HSA plans

| | Bronze plans | |
|---|---|---|
| **Plan name** | **Anthem Bronze PPO 6000/45% w/HSA PrevRx Ω** | **Anthem Bronze PPO 7400/0% w/HSA PrevRx** |
| Network (contract codes) | Prudent Buyer PPO (1GKG)<br>Select PPO (12YP) | Prudent Buyer PPO (1G9Q)<br>Select PPO (1GKM) |
| In-network deductible (individual/family) | $6,000/$12,000 | $7,400/$14,800 |
| Out-of-network deductible (individual/family) | $12,000/$24,000 | $14,800/$29,600 |
| In-network coinsurance | 45% | 0% |
| Out-of-network coinsurance | 50% | 50% |
| In-network out-of-pocket maximum (individual/family) | $8,300/$16,600 | $8,700/$17,400 |
| Out-of-network out-of-pocket maximum (individual/family) | $16,600/$33,200 | $17,400/$34,800 |
| 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] | Covered in full | 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<br>Level 2: $20/$100/$170/40% up to $500 per script | Level 1: $20/$90/$160/30% up to $400 per script<br>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 | Pediatric dental and vision covered<br>Adult dental not covered, eye exam only covered | Pediatric dental and vision covered<br>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 drug tiers 1-3 and up to a 30-day supply for drug tier 4 (Specialty drugs).

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# Small Group EmployeeElect product details – groups of 1-100 employees

## SHOP Mirror plans

| | Platinum plans | Gold plans | Silver plans |
|---|---|---|---|
| **Plan name** | **Anthem Platinum Select PPO 25/10% Mirror** | **Anthem Gold Select PPO 30/500/20% Mirror** | **Anthem Silver Select PPO 60/2500/40% Mirror** |
| Network (contract codes) | Select PPO (1GGH) | Select PPO (1GRA) | Select PPO (1GQQ) |
| In-network deductible (individual/family) | $0/$0 | $500/$1,000 | $2,500/$5,000 |
| Out-of-network deductible (individual/family) | $2,000/$4,000 | $2,000/$4,000 | $5,000/$10,000 |
| In-network coinsurance | 10% | 20% | 40% |
| Out-of-network coinsurance | 50% | 50% | 50% |
| In-network out-of-pocket maximum (individual/family) | $5,000/$10,000 | $8,600/$17,200 | $9,000/$18,000 |
| Out-of-network out-of-pocket maximum (individual/family) | $10,000/$20,000 | $17,200/$34,400 | $18,000/$36,000 |
| Office and virtual visits[1]: Primary care (PCP)/ Specialist (SPC) | PCP: $25<br>SPC: $40 | PCP: $30<br>SPC: $60 | PCP: $60<br>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) | $25 | $30 | $60 |
| Emergency room (facility) | $250 | Deductible, then 20% coinsurance | Deductible, then 40% coinsurance |
| Independent facility: ambulatory outpatient surgery center | 10% coinsurance | 20% coinsurance | Deductible, then 40% coinsurance |
| Hospital outpatient surgery facility | 10% coinsurance | 20% coinsurance | Deductible, then 40% coinsurance |
| Hospital inpatient admission | 10% coinsurance | Deductible, then 20% coinsurance | Deductible, then 40% coinsurance |
| Prescription drugs: network/drug list | Advantage with R90/Select | Advantage with R90/Select | Advantage with R90/Select |
| Pharmacy deductible[3] (individual/family) | Tiers 1-4: No deductible | Tiers 1-4: No deductible | Tier 1: No deductible<br>Tiers 2-4: $350/$700 Pharmacy deductible |
| Retail pharmacy: 30-day supply (tier 1/tier 2/tier 3/tier 4) | $10/$30/$40/10% up to $250 per script | $20/$50/$80/20% up to $250 per script | $25/$80/$110/30% up to $250 per script |
| Home delivery pharmacy[4] (tier 1/tier 2/tier 3/tier 4) | $20/$75/$100/10% up to $250 per script | $40/$125/$200/20% up to $250 per script | $50/$200/$275/30% up to $250 per script |
| Dental and vision | Pediatric dental and vision covered<br>Adult dental not covered, eye exam only covered | Pediatric dental and vision covered<br>Adult dental not covered, eye exam only covered | Pediatric dental and vision covered<br>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.

◊ 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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# Small Group EmployeeElect product details – groups of 1-100 employees

## SHOP Mirror plans

| | Bronze plans |
|---|---|
| **Plan name** | **Anthem Bronze Select PPO 7800/0% w/HSA Mirror** |
| Network (contract codes) | Select PPO (1GR9) |
| In-network deductible (individual/family) | $7,800/$15,600 |
| Out-of-network deductible (individual/family) | $15,600/$31,200 |
| In-network coinsurance | 0% |
| Out-of-network coinsurance | 50% |
| In-network out-of-pocket maximum (individual/family) | $7,800/$15,600 |
| Out-of-network out-of-pocket maximum (individual/family) | $19,500/$39,000 |
| Office and virtual visits[1]: Primary care (PCP)/ Specialist (SPC) | Deductible, then 0% coinsurance |
| Virtual primary care and urgent/acute care services: Virtual care-only provider[2] | Covered in full |
| Urgent care (office) | Deductible, then 0% coinsurance |
| Emergency room (facility) | Deductible, then 0% coinsurance |
| Independent facility: ambulatory outpatient surgery center | Deductible, then 0% coinsurance |
| Hospital outpatient surgery facility | Deductible, then 0% coinsurance |
| Hospital inpatient admission | Deductible, then 0% coinsurance |
| Prescription drugs: network/drug list | Advantage with R90/Select |
| Pharmacy deductible[3] (individual/family) | Tiers 1-4: Medical deductible applies |
| Retail pharmacy: 30-day supply (tier 1/tier 2/tier 3/tier 4) | 0% |
| Home delivery pharmacy[4] (tier 1/tier 2/tier 3/tier 4) | 0% |
| Dental and vision | Pediatric dental and vision covered<br>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.

◊ 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 1-100 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) | CaliforniaCare HMO (1GKF)<br>Small Group Priority Select HMO (1304)<br>Select HMO (1GQP) | CaliforniaCare HMO (1GRH)<br>Small Group Priority Select HMO (12YS)<br>Select HMO (130Q) | CaliforniaCare HMO (1306)<br>Small Group Priority Select HMO (12ZU)<br>Select HMO (1GHU) |
| 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) | $4,100/$8,200 | $3,400/$6,800 | $3,100/$6,200 |
| 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: $20<br>SPC: $40 | PCP: $25<br>SPC: $50 | PCP: $30<br>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) | $400 | $400 | $275 |
| Independent facility: ambulatory outpatient surgery center | $100 | $150 | $250 |
| Hospital outpatient surgery facility | $200 | $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: $10/$25/$50/30% up to $250 per script<br>Level 2: $20/$35/$60/40% up to $250 per script | Level 1: $10/$25/$50/30% up to $250 per script<br>Level 2: $20/$35/$60/40% up to $250 per script | Level 1: $5/$30/$50/30% up to $250 per script<br>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/$125/30% up to $250 per script | $20/$63/$125/30% up to $250 per script | $10/$75/$125/30% up to $250 per script |
| Dental and vision | Pediatric dental and vision covered<br>Adult dental not covered, eye exam only covered | Pediatric dental and vision covered<br>Adult dental not covered, eye exam only covered | Pediatric dental and vision covered<br>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 1-100 employees

## Anthem HMO plans

| | Gold plans | | |
|---|---|---|---|
| **Plan name** | **Anthem Gold HMO 30 Ω** | **Anthem Gold HMO 35 Ω** | **Anthem Gold HMO 35/500/20% Ω** |
| Network (contract codes) | CaliforniaCare HMO (1GSD)<br>Small Group Priority Select HMO (1G9J)<br>Select HMO (1G9N) | CaliforniaCare HMO (1GQA)<br>Small Group Priority Select HMO (1GRK)<br>Select HMO (1GRU) | CaliforniaCare HMO (1GS4)<br>Small Group Priority Select HMO (1GQT)<br>Select HMO (12YU) |
| 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 | 0% | 0% | 20% |
| Out-of-network coinsurance | Not applicable | Not applicable | Not applicable |
| In-network out-of-pocket maximum (individual/family) | $7,700/$15,400 | $7,300/$14,600 | $10,000/$20,000 |
| 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: $30<br>SPC: $60 | PCP: $35<br>SPC: $70 | PCP: $35<br>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 | $35 |
| Emergency room (facility) | $500 | $325 | Deductible, then $500 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: $20/$50/$90/30% up to $250 per script<br>Level 2: $25/$70/$100/40% up to $250 per script | Level 1: $10/$50/$90/30% up to $250 per script<br>Level 2: $20/$60/$100/40% up to $250 per script | Level 1: $20/$50/$90/30% up to $250 per script<br>Level 2: $30/$60/$100/40% up to $250 per script |
| Home delivery pharmacy[4] (tier 1/tier 2/tier 3/tier 4) | $40/$125/$225/30% up to $250 per script | $20/$125/$225/30% up to $250 per script | $40/$125/$225/30% up to $250 per script |
| Dental and vision | Pediatric dental and vision covered<br>Adult dental not covered, eye exam only covered | Pediatric dental and vision covered<br>Adult dental not covered, eye exam only covered | Pediatric dental and vision covered<br>Adult dental not covered, eye exam only covered |

### Footnotes

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# Small Group EmployeeElect product details – groups of 1-100 employees

## Anthem HMO plans

| | Gold plans | Silver plans | |
|---|---|---|---|
| **Plan name** | **Anthem Gold HMO 35/1250/20% Ω** | **Anthem Silver HMO 55 Ω** | **Anthem Silver HMO 60/2500/45% Ω** |
| Network (contract codes) | CaliforniaCare HMO (12ZX)<br>Small Group Priority Select HMO (1GKK)<br>Select HMO (1GRQ) | CaliforniaCare HMO (1GRD)<br>Select HMO (1GS0) | CaliforniaCare HMO (12YT)<br>Select HMO (1GP3) |
| In-network deductible (individual/family) | $1,250/$2,500 | $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) | $8,600/$17,200 | $12,000/$24,000 | $11,200/$22,400 |
| 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: $35<br>SPC: $60 | PCP: $55<br>SPC: $110 | PCP: $60<br>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 | $1,000 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<br>Tiers 2-4: $400/$800 Pharmacy deductible | Tier 1: No deductible<br>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<br>Level 2: $20/$60/$100/40% up to $250 per script | Level 1: $20/$95/$150/30% up to $250 per script<br>Level 2: $25/$105/$160/40% up to $250 per script | Level 1: $10/$70/$110/30% up to $250 per script<br>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<br>Adult dental not covered, eye exam only covered | Pediatric dental and vision covered<br>Adult dental not covered, eye exam only covered | Pediatric dental and vision covered<br>Adult dental not covered, eye exam only covered |

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# Small Group EmployeeElect product details – groups of 1-100 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 (1GSC) | Vivity (1GR2) | Vivity (130K) |
| 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) | $3,200/$6,400 | $9,250/$18,500 | $6,600/$13,200 |
| 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: $15<br>SPC: $30 | PCP: $25<br>SPC: $50 | PCP: $25<br>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<br>Tier 4: Medical deductible applies |
| Retail pharmacy: 30-day supply (tier 1/tier 2/tier 3/tier 4) | Level 1: $5/$25/$75/$250<br>Level 2: $15/$35/$85/$250 | Level 1: $10/$40/$100/$250<br>Level 2: $20/$50/$110/$250 | Level 1: $10/$40/$100/$250<br>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<br>Adult dental not covered, eye exam only covered | Pediatric dental and vision covered<br>Adult dental not covered, eye exam only covered | Pediatric dental and vision covered<br>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.

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 drug tiers 1-3 and up to a 30-day supply for drug tier 4 (Specialty drugs).

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# Small Group EmployeeElect product details – groups of 1-100 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 (1GS9) | Vivity (1GRT) |
| 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<br>SPC: $75 | PCP: $35<br>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<br>Tier 4: Medical deductible applies | Tiers 1-3: No deductible<br>Tier 4: Medical deductible applies |
| Retail pharmacy: 30-day supply (tier 1/tier 2/tier 3/tier 4) | Level 1: $10/$40/$100/$250<br>Level 2: $20/$50/$110/$250 | Level 1: $10/$40/$100/$250<br>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<br>Adult dental not covered, eye exam only covered | Pediatric dental and vision covered<br>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.

◊ 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 1-100 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 (1GSF) | Prudent Buyer PPO (1GQH) | Prudent Buyer PPO (1GS1) |
| 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) | $4,000/$8,000 | $8,200/$16,400 | $8,200/$16,400 |
| Out-of-network out-of-pocket maximum (individual/family) | $8,000/$16,000 | $16,400/$32,800 | $16,400/$32,800 |
| Office and virtual visits[1]: Primary care (PCP)/ Specialist (SPC) | PCP: $5<br>SPC: $45 | PCP: $35<br>SPC: $65 | PCP: $35<br>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<br>Tiers 2-4: $250/$500 Pharmacy deductible | Tier 1: No deductible<br>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<br>Level 2: $15/$40/$60/40% up to $250 per script | Level 1: $10/$50/$90/30% up to $250 per script<br>Level 2: $20/$60/$100/40% up to $250 per script | Level 1: $5/$60/$110/30% up to $250 per script<br>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<br>Adult dental and vision covered | Enhanced pediatric dental and vision covered<br>Adult dental and vision covered | Enhanced pediatric dental and vision covered<br>Adult dental and vision 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.

◊ 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 1-100 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 (12ZW)<br>Select PPO (1GQJ) | Prudent Buyer PPO (1GRW) |
| 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) | $10,550/$21,100 | $9,500/$19,000 |
| Out-of-network out-of-pocket maximum (individual/family) | $21,100/$42,200 | $19,000/$38,000 |
| Office and virtual visits[1]: Primary care (PCP)/ Specialist (SPC) | PCP: $45<br>SPC: $95 | PCP: $55<br>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 $500 and 40% coinsurance | Deductible, then $100 and 45% coinsurance |
| Independent facility: ambulatory outpatient surgery center | Deductible, then $150 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<br>Tiers 2-4: $300/$600 Pharmacy deductible | Tier 1: No deductible<br>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<br>Level 2: $20/$80/$120/40% up to $250 per script | Level 1: $15/$70/$110/30% up to $250 per script<br>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<br>Adult dental and vision covered | Enhanced pediatric dental and vision covered<br>Adult dental and vision 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.

◊ 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 1-100 employees

## Anthem PPO HSA Whole Health plans

| | Bronze plans | |
|---|---|---|
| **Plan name** | **Anthem Bronze PPO 6000/45% w/HSA PrevRx WH Ω** | **Anthem Bronze PPO 7400/0% w/HSA PrevRx WH** |
| Network (contract codes) | Prudent Buyer PPO (1GS7) | Prudent Buyer PPO (1GR3) |
| In-network deductible (individual/family) | $6,000/$12,000 | $7,400/$14,800 |
| Out-of-network deductible (individual/family) | $12,000/$24,000 | $14,800/$29,600 |
| In-network coinsurance | 45% | 0% |
| Out-of-network coinsurance | 50% | 50% |
| In-network out-of-pocket maximum (individual/family) | $8,300/$16,600 | $8,700/$17,400 |
| Out-of-network out-of-pocket maximum (individual/family) | $16,600/$33,200 | $17,400/$34,800 |
| 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] | Covered in full | 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<br>Level 2: $20/$100/$170/40% up to $500 per script | Level 1: $20/$90/$160/30% up to $400 per script<br>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<br>Adult dental and vision covered | Enhanced pediatric dental and vision covered<br>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.

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# Small Group EmployeeElect product details – groups of 1-100 employees

## Anthem HMO Whole Health plans

| | Silver plans |
|---|---|
| **Plan name** | **Anthem Silver Select HMO 60/2500/45% WH Ω** |
| Network (contract codes) | Select HMO (1GRL) |
| 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) | $11,200/$22,400 |
| Out-of-network out-of-pocket maximum (individual/family) | Not applicable |
| Office and virtual visits[1]: Primary care (PCP)/ Specialist (SPC) | PCP: $60<br>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<br>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<br>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<br>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 1-100 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 (1GQM) | Vivity (1GQ8) | Vivity (1GKE) |
| 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) | $3,200/$6,400 | $9,250/$18,500 | $6,600/$13,200 |
| 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: $15<br>SPC: $30 | PCP: $25<br>SPC: $50 | PCP: $25<br>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<br>Tier 4: Medical deductible applies |
| Retail pharmacy: 30-day supply (tier 1/tier 2/tier 3/tier 4) | Level 1: $5/$25/$75/$250<br>Level 2: $15/$35/$85/$250 | Level 1: $10/$40/$100/$250<br>Level 2: $20/$50/$110/$250 | Level 1: $10/$40/$100/$250<br>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<br>Adult dental and vision covered | Enhanced pediatric dental and vision covered<br>Adult dental and vision covered | Enhanced pediatric dental and vision covered<br>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 drug tiers 1-3 and up to a 30-day supply for drug tier 4 (Specialty drugs).

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# Small Group EmployeeElect product details – groups of 1-100 employees

## 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 (1GRN) | Vivity (130L) |
| 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<br>SPC: $75 | PCP: $35<br>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<br>Tier 4: Medical deductible applies | Tiers 1-3: No deductible<br>Tier 4: Medical deductible applies |
| Retail pharmacy: 30-day supply (tier 1/tier 2/tier 3/tier 4) | Level 1: $10/$40/$100/$250<br>Level 2: $20/$50/$110/$250 | Level 1: $10/$40/$100/$250<br>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<br>Adult dental and vision covered | Enhanced pediatric dental and vision covered<br>Adult dental and vision 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.

◊ 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 drug tiers 1-3 and up to a 30-day supply for drug tier 4 (Specialty drugs).

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