



California

Effective July 1, 2023

Small Group medical product guide

Anthem  | SMALL BUSINESS

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 SydneySM 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.

Small Group Employee Elect product details – groups of 1 to 100 employees

***NEW* for July, 2023**

- Offering some of our most popular plans with and without a drug deductible.
- | | |
|-----------------------------|--|
| <u>No Rx Deductible</u> | <u>Includes \$150 Rx Deductible</u> |
| Anthem Gold HMO 35/500/20% | Anthem Gold HMO 35/500/20% RxD |
| Anthem Gold HMO 35/1250/20% | Anthem Gold HMO 35/1250/20% RxD |
| Anthem Gold PPO 25/30% | Anthem Gold PPO 25/30% RxD |
| Anthem Gold PPO 30/500/20% | Anthem Gold PPO 30/500/20% RxD |

***NEW* for January, 2023 (All Plans)**

- Urgent care aligns with the PCP copay on our PPO plans.
- Chiropractic benefit through American Specialty Health covered at a flat \$15 copay with a 30 visit limit for HMO plans only. No referral required.

Anthem Link Vivity HMO plans:

- Virtual primary care visits with a member's in-network doctor and virtual preferred online provider (video visits) covered in full (no cost share). Other services such as PCP office visits and Specialist visits covered at copay.

Pharmacy benefits:

- All plans use the Rx Choice Tiered Network with R90 (except SHOP mirror) which includes a choice of two levels – Level 1 (preferred) or Level 2 (non-preferred) – with access to more than 66,000 pharmacies across the country, including chains like CVS and Walgreens.
- SHOP mirror plans use the Advantage with R90 network. Walgreens is not in network and is not covered.
- All plans use the Select Drug List.

Dental and vision benefits:

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

Whole Health plans:

- Our Whole Health plans (plans with **WH** at the end of the plan name) include enhanced pediatric dental and adult dental benefits along with enhanced adult vision benefits.
- Embedded dental benefits include:
 - In-network diagnostic and preventive dental services covered at no cost.
 - Other dental services subject to a \$50 deductible, 20% coinsurance for basic services, and 50% coinsurance for major services.
 - \$1,000 annual dental benefit maximum.
 - Enhanced dental benefits for children and adults.
 - No waiting period.
- Embedded vision benefits include:
 - Coverage of annual eye exams.
 - Coverage of materials.
- Take a look at our **Whole Health flier** for more details about these benefits.

Small Group EmployeeElect product details – groups of 1 to 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
- 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 Employee Elect 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 code)	Select PPO (6RJJ)	Prudent Buyer PPO (6RH4) Select PPO (6RHY)	Prudent Buyer PPO (6RJP) Select PPO (6RJT)
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	\$3,800/\$7,600
Out-of-network out-of-pocket maximum (individual/family)	\$9,000/\$18,000	\$7,600/\$15,200	\$7,600/\$15,200
Office and virtual visits ¹ : Primary care (PCP)/Specialist (SPC)	PCP: \$15 SPC: \$30	PCP: \$15 SPC: \$40	PCP: \$5 SPC: \$45
Virtual doctor visits: Preferred online 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	10% coinsurance	Deductible, then 15% coinsurance
Hospital outpatient surgery facility	10% coinsurance	\$150, then 10% coinsurance	Deductible, then \$200 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)	\$25/\$63/\$100/10% up to \$250 per script	\$13/\$90/\$150/30% up to \$250 per script	\$13/\$90/\$150/30% 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.

◇ These plans have a different deductible amount if the subscriber is enrolled as self only or has enrolled dependents in the plan. 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.

§ A limited number of benefits use coinsurance - home dialysis, home infusion therapy, diabetic supplies, durable medical equipment (DME) and prosthetics. In plans that have a deductible, these cost shares apply after plan deductible.

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 Anthem Link plans which are covered in full for non-HSA plans and subject to deductible, then covered in full for HSA plans.

2 Cost share applies to virtual visits from our online provider LiveHealth Online (LHO) - urgent/acute medical and behavioral health services (mental health / substance abuse). In addition, free visits for Future Moms Breastfeeding Support and EAP counseling visits on LHO are included with all Anthem medical plans.

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 Employee Elect 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 PPO 25/30% RxD Ω *NEW*
Network (contract code)	Prudent Buyer PPO (6RG6) Select PPO (6RHD)	Prudent Buyer PPO (6RFN) Select PPO (6RGD)	Prudent Buyer PPO (8NAG) Select PPO (8NAG)
In-network deductible (individual/family)	\$250/\$750	\$0/\$0	\$0/\$0
Out-of-network deductible (individual/family)	\$2,000/\$4,000	\$2,000/\$4,000	\$2,000/\$4,000
In-network coinsurance	10%	30%	30%
Out-of-network coinsurance	50%	50%	50%
In-network out-of-pocket maximum (individual/family)	\$3,800/\$7,600	\$8,200/\$16,400	\$8,200/\$16,400
Out-of-network out-of-pocket maximum (individual/family)	\$7,600/\$15,200	\$16,400/\$32,800	\$16,400/\$32,800
Office and virtual visits ¹ : Primary care (PCP)/Specialist (SPC)	PCP: \$15 SPC: \$30	PCP: \$25 SPC: \$50	PCP: \$25 SPC: \$50
Virtual doctor visits: Preferred online 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	\$250, then 30% coinsurance	\$250, then 30% coinsurance
Independent facility: ambulatory outpatient surgery center	Deductible, then 10% coinsurance	30% coinsurance	30% coinsurance
Hospital outpatient surgery facility	Deductible, then \$200 and 10% coinsurance	\$200, then 30% coinsurance	\$200, then 30% coinsurance
Hospital inpatient admission	Deductible, then 10% coinsurance	30% coinsurance	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: No deductible	Tiers 1-4: No deductible	Tier 1: No deductible Tiers 2-4: \$150/\$300 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: \$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)	\$13/\$90/\$150/30% up to \$250 per script	\$25/\$150/\$270/30% up to \$250 per script	\$25/\$150/\$270/30% 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.

◇ These plans have a different deductible amount if the subscriber is enrolled as self only or has enrolled dependents in the plan. 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.

§ A limited number of benefits use coinsurance - home dialysis, home infusion therapy, diabetic supplies, durable medical equipment (DME) and prosthetics. In plans that have a deductible, these cost shares apply after plan deductible.

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 Anthem Link plans which are covered in full for non-HSA plans and subject to deductible, then covered in full for HSA plans.

2 Cost share applies to virtual visits from our online provider LiveHealth Online (LHO) - urgent/acute medical and behavioral health services (mental health / substance abuse). In addition, free visits for Future Moms Breastfeeding Support and EAP counseling visits on LHO are included with all Anthem medical plans.

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 Employee Elect product details – groups of 1 to 100 employees

Anthem PPO plans

	Gold plans		
Plan name	Anthem Gold Select PPO 25/350/20%	Anthem Gold PPO 30/500/20% Ω	Anthem Gold PPO 30/500/20% RxD Ω *NEW*
Network (contract code)	Select PPO (6RGH)	Prudent Buyer PPO (6RG9) Select PPO (6RHX)	Prudent Buyer PPO (8NAP) Select PPO (8NCE)
In-network deductible (individual/family)	\$350/\$700	\$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	20%	20%	20%
Out-of-network coinsurance	50%	50%	50%
In-network out-of-pocket maximum (individual/family)	\$7,800/\$15,600	\$7,900/\$15,800	\$7,900/\$15,800
Out-of-network out-of-pocket maximum (individual/family)	\$15,600/\$31,200	\$15,800/\$31,600	\$15,800/\$31,600
Office and virtual visits ¹ : Primary care (PCP)/Specialist (SPC)	PCP: \$25 SPC: \$50	PCP: \$30 SPC: \$60	PCP: \$30 SPC: \$60
Virtual doctor visits: Preferred online provider ²	Covered in full	Covered in full	Covered in full
Urgent care (office)	\$25	\$30	\$30
Emergency room (facility)	Deductible, then 20% coinsurance	Deductible, then \$250 and 20% coinsurance	Deductible, then \$250 and 20% coinsurance
Independent facility: ambulatory outpatient surgery center	20% coinsurance	Deductible, then 20% coinsurance	Deductible, then 20% coinsurance
Hospital outpatient surgery facility	20% coinsurance	Deductible, then \$200 and 20% coinsurance	Deductible, then \$200 and 20% coinsurance
Hospital inpatient admission	Deductible, then 20% coinsurance	Deductible, then 20% coinsurance	Deductible, then 20% 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	Tier 1: No deductible Tiers 2-4: \$150/\$300 Pharmacy deductible
Retail pharmacy: 30-day supply (tier 1/tier 2/tier 3/tier 4)	\$15/\$50/\$80/20% 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)	\$38/\$125/\$200/20% up to \$250 per script	\$25/\$150/\$270/30% up to \$250 per script	\$25/\$150/\$270/30% 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.

◇ These plans have a different deductible amount if the subscriber is enrolled as self only or has enrolled dependents in the plan. 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.

§ A limited number of benefits use coinsurance - home dialysis, home infusion therapy, diabetic supplies, durable medical equipment (DME) and prosthetics. In plans that have a deductible, these cost shares apply after plan deductible.

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 Anthem Link plans which are covered in full for non-HSA plans and subject to deductible, then covered in full for HSA plans.

2 Cost share applies to virtual visits from our online provider LiveHealth Online (LHO) - urgent/acute medical and behavioral health services (mental health / substance abuse). In addition, free visits for Future Moms Breastfeeding Support and EAP counseling visits on LHO are included with all Anthem medical plans.

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 Employee Elect product details – groups of 1 to 100 employees

Anthem PPO plans

	Gold plans		
Plan name	Anthem Gold PPO 35/500/25% Ω	Anthem Gold PPO 30/750/20% Ω	Anthem Gold PPO 35/1000/20% Ω
Network (contract code)	Prudent Buyer PPO (6RGV) Select PPO (6RH7)	Prudent Buyer PPO (6RGS) Select PPO (6RFP)	Prudent Buyer PPO (6RH1) Select PPO (6RFM)
In-network deductible (individual/family)	\$500/\$1,500	\$750/\$2,250	\$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	25%	20%	20%
Out-of-network coinsurance	50%	50%	50%
In-network out-of-pocket maximum (individual/family)	\$8,200/\$16,400	\$8,200/\$16,400	\$8,200/\$16,400
Out-of-network out-of-pocket maximum (individual/family)	\$16,400/\$32,800	\$16,400/\$32,800	\$16,400/\$32,800
Office and virtual visits ¹ : Primary care (PCP)/Specialist (SPC)	PCP: \$35 SPC: \$65	PCP: \$30 SPC: \$55	PCP: \$35 SPC: \$60
Virtual doctor visits: Preferred online provider ²	Covered in full	Covered in full	Covered in full
Urgent care (office)	\$35	\$30	\$35
Emergency room (facility)	Deductible, then \$250 and 25% coinsurance	Deductible, then \$250 and 20% coinsurance	Deductible, then \$250 and 20% coinsurance
Independent facility: ambulatory outpatient surgery center	Deductible, then 25% coinsurance	Deductible, then 20% coinsurance	Deductible, then 20% coinsurance
Hospital outpatient surgery facility	Deductible, then \$200 and 25% coinsurance	Deductible, then \$200 and 20% coinsurance	Deductible, then \$200 and 20% coinsurance
Hospital inpatient admission	Deductible, then 25% coinsurance	Deductible, then 20% 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)	Tier 1: No deductible Tiers 2-4: \$250/\$500 Pharmacy 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: \$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: \$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)	\$25/\$150/\$270/30% up to \$250 per script	\$25/\$150/\$270/30% up to \$250 per script	\$13/\$180/\$330/30% 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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◇ These plans have a different deductible amount if the subscriber is enrolled as self only or has enrolled dependents in the plan. 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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Small Group Employee Elect product details – groups of 1 to 100 employees

Anthem PPO plans

	Gold plans	Silver plans	
Plan name	Anthem Gold PPO 5/1500/30% Ω	Anthem Silver PPO 45/1750/40% Ω	Anthem Silver PPO 55/1950/35% Ω
Network (contract code)	Prudent Buyer PPO (6RK1) Select PPO (6RJD)	Prudent Buyer PPO (6RGX) Select PPO (6RGW)	Prudent Buyer PPO (6RJ0) Select PPO (6RHJ)
In-network deductible (individual/family)	\$1,500/\$3,000	\$1,750/\$3,500	\$1,950/\$3,900
Out-of-network deductible (individual/family)	\$3,000/\$6,000	\$3,500/\$7,000	\$3,900/\$7,800
In-network coinsurance	30%	40%	35%
Out-of-network coinsurance	50%	50%	50%
In-network out-of-pocket maximum (individual/family)	\$8,300/\$16,600	\$9,100/\$18,200	\$9,100/\$18,200
Out-of-network out-of-pocket maximum (individual/family)	\$16,600/\$33,200	\$18,200/\$36,400	\$18,200/\$36,400
Office and virtual visits ¹ : Primary care (PCP)/Specialist (SPC)	PCP: \$5 SPC: \$65	PCP: \$45 SPC: \$95	PCP: \$55 SPC: \$90
Virtual doctor visits: Preferred online provider ²	Covered in full	Covered in full	Covered in full
Urgent care (office)	\$5	\$45	\$55
Emergency room (facility)	Deductible, then \$250 and 30% coinsurance	Deductible, then \$300 and 40% coinsurance	Deductible, then \$350 and 35% coinsurance
Independent facility: ambulatory outpatient surgery center	Deductible, then 30% coinsurance	Deductible, then 40% coinsurance	Deductible, then 35% coinsurance
Hospital outpatient surgery facility	Deductible, then \$200 and 30% coinsurance	Deductible, then \$250 and 40% coinsurance	Deductible, then \$200 and 35% coinsurance
Hospital inpatient admission	Deductible, then 30% 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	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: \$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)	\$13/\$180/\$330/30% up to \$250 per script	\$38/\$210/\$330/30% up to \$250 per script	\$38/\$210/\$330/30% 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.

◇ These plans have a different deductible amount if the subscriber is enrolled as self only or has enrolled dependents in the plan. 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.

§ A limited number of benefits use coinsurance - home dialysis, home infusion therapy, diabetic supplies, durable medical equipment (DME) and prosthetics. In plans that have a deductible, these cost shares apply after plan deductible.

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 Anthem Link plans which are covered in full for non-HSA plans and subject to deductible, then covered in full for HSA plans.

2 Cost share applies to virtual visits from our online provider LiveHealth Online (LHO) - urgent/acute medical and behavioral health services (mental health / substance abuse). In addition, free visits for Future Moms Breastfeeding Support and EAP counseling visits on LHO are included with all Anthem medical plans.

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 Employee Elect product details – groups of 1 to 100 employees

Anthem PPO plans

	Silver plans		
Plan name	Anthem Silver PPO 50/2200/40% Ω	Anthem Silver Select PPO 55/2500/35%	Anthem Silver PPO 55/2500/45% Ω
Network (contract code)	Prudent Buyer PPO (6RK6) Select PPO (6RJF)	Select PPO (6RFU)	Prudent Buyer PPO (6RFY) Select PPO (6RGB)
In-network deductible (individual/family)	\$2,200/\$4,400	\$2,500/\$5,000	\$2,500/\$5,000
Out-of-network deductible (individual/family)	\$4,400/\$8,800	\$5,000/\$10,000	\$5,000/\$10,000
In-network coinsurance	40%	35%	45%
Out-of-network coinsurance	50%	50%	50%
In-network out-of-pocket maximum (individual/family)	\$8,600/\$17,200	\$8,600/\$17,200	\$8,700/\$17,400
Out-of-network out-of-pocket maximum (individual/family)	\$17,200/\$34,400	\$17,200/\$34,400	\$17,400/\$34,800
Office and virtual visits ¹ : Primary care (PCP)/Specialist (SPC)	PCP: \$50 SPC: \$90	PCP: \$55 SPC: \$90	PCP: \$55 SPC: \$90
Virtual doctor visits: Preferred online provider ²	Covered in full	Covered in full	Covered in full
Urgent care (office)	\$50	\$55	\$55
Emergency room (facility)	Deductible, then \$350 and 40% coinsurance	Deductible, then 35% coinsurance	Deductible, then \$100 and 45% coinsurance
Independent facility: ambulatory outpatient surgery center	Deductible, then 40% coinsurance	Deductible, then 35% coinsurance	Deductible, then 45% coinsurance
Hospital outpatient surgery facility	Deductible, then \$200 and 40% coinsurance	Deductible, then 35% coinsurance	Deductible, then \$200 and 45% coinsurance
Hospital inpatient admission	Deductible, then 40% coinsurance	Deductible, then 35% coinsurance	Deductible, then 45% coinsurance
Prescription drugs: network/drug list	Rx Choice Tiered Network with R90/ Select	Advantage 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: \$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	\$20/\$75/\$105/30% 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)	\$38/\$210/\$330/30% up to \$250 per script	\$50/\$188/\$263/30% up to \$250 per script	\$38/\$210/\$330/30% 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.

◇ These plans have a different deductible amount if the subscriber is enrolled as self only or has enrolled dependents in the plan. 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.

§ A limited number of benefits use coinsurance - home dialysis, home infusion therapy, diabetic supplies, durable medical equipment (DME) and prosthetics. In plans that have a deductible, these cost shares apply after plan deductible.

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 Anthem Link plans which are covered in full for non-HSA plans and subject to deductible, then covered in full for HSA plans.

2 Cost share applies to virtual visits from our online provider LiveHealth Online (LHO) - urgent/acute medical and behavioral health services (mental health / substance abuse). In addition, free visits for Future Moms Breastfeeding Support and EAP counseling visits on LHO are included with all Anthem medical plans.

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

	Bronze plans		
Plan name	Anthem Bronze PPO 4600/50% Ω	Anthem Bronze PPO 40/6200/40% Ω	Anthem Bronze PPO 70/6600/35% Ω
Network (contract code)	Prudent Buyer PPO (6RJX) Select PPO (6RH9)	Prudent Buyer PPO (6RJN) Select PPO (6RJS)	Prudent Buyer PPO (6RFV) Select PPO (6RFR)
In-network deductible (individual/family)	\$4,600/\$9,200	\$6,200/\$12,400	\$6,600/\$13,200
Out-of-network deductible (individual/family)	\$9,200/\$18,400	\$12,400/\$24,800	\$13,200/\$26,400
In-network coinsurance	50%	40%	35%
Out-of-network coinsurance	50%	50%	50%
In-network out-of-pocket maximum (individual/family)	\$8,100/\$16,200	\$8,700/\$17,400	\$8,700/\$17,400
Out-of-network out-of-pocket maximum (individual/family)	\$16,200/\$32,400	\$17,400/\$34,800	\$17,400/\$34,800
Office and virtual visits ¹ : Primary care (PCP)/Specialist (SPC)	Deductible, then 50% coinsurance	PCP: Deductible, then \$40 SPC: Deductible, then \$80	PCP: Deductible, then \$70 SPC: Deductible, then \$85
Virtual doctor visits: Preferred online provider ²	Deductible, then covered in full	Covered in full	Covered in full
Urgent care (office)	Deductible, then 50% coinsurance	Deductible, then \$40	Deductible, then \$70
Emergency room (facility)	Deductible, then 50% coinsurance	Deductible, then \$250 and 40% coinsurance	Deductible, then \$250 and 35% coinsurance
Independent facility: ambulatory outpatient surgery center	Deductible, then 40% coinsurance	Deductible, then 40% coinsurance	Deductible, then 35% coinsurance
Hospital outpatient surgery facility	Deductible, then 50% coinsurance	Deductible, then \$200 and 40% coinsurance	Deductible, then \$200 and 35% coinsurance
Hospital inpatient admission	Deductible, then 50% 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	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: 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: \$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	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)	\$50/\$240/\$360/30% up to \$400 per script	\$50/\$240/\$360/30% up to \$400 per script	\$50/\$240/\$360/30% 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.

◇ These plans have a different deductible amount if the subscriber is enrolled as self only or has enrolled dependents in the plan. 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.

§ A limited number of benefits use coinsurance - home dialysis, home infusion therapy, diabetic supplies, durable medical equipment (DME) and prosthetics. In plans that have a deductible, these cost shares apply after plan deductible.

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 Anthem Link plans which are covered in full for non-HSA plans and subject to deductible, then covered in full for HSA plans.

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Small Group Employee Elect product details – groups of 1 to 100 employees

Anthem PPO plans

	Bronze plans	
Plan name	Anthem Bronze PPO 60/6850/40% Ω	Anthem Bronze PPO 75/7300/40% Ω
Network (contract code)	Prudent Buyer PPO (6RK4) Select PPO (6RHK)	Prudent Buyer PPO (6RJ1) Select PPO (6RGT)
In-network deductible (individual/family)	\$6,850/\$13,700	\$7,300/\$14,600
Out-of-network deductible (individual/family)	\$13,700/\$27,400	\$14,600/\$29,200
In-network coinsurance	40%	40%
Out-of-network coinsurance	50%	50%
In-network out-of-pocket maximum (individual/family)	\$8,200/\$16,400	\$8,650/\$17,300
Out-of-network out-of-pocket maximum (individual/family)	\$16,400/\$32,800	\$17,300/\$34,600
Office and virtual visits ¹ : Primary care (PCP)/Specialist (SPC)	PCP: Deductible, then \$60 SPC: Deductible, then \$80	PCP: \$75 SPC: \$110
Virtual doctor visits: Preferred online provider ²	Covered in full	Covered in full
Urgent care (office)	Deductible, then \$60	\$75
Emergency room (facility)	Deductible, then \$250 and 40% coinsurance	Deductible, then \$250 and 40% coinsurance
Independent facility: ambulatory outpatient surgery center	Deductible, then 40% coinsurance	Deductible, then 40% coinsurance
Hospital outpatient surgery facility	Deductible, then \$200 and 40% coinsurance	Deductible, then \$200 and 40% coinsurance
Hospital inpatient admission	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
Pharmacy deductible ³ (individual/family)	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/\$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)	\$50/\$270/\$480/30% up to \$400 per script	\$50/\$270/\$480/30% 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

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. 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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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 Employee Elect product details – groups of 1 to 100 employees

Anthem PPO HSA plans

	Gold plans	Silver plans	
Plan name	Anthem Gold PPO 1700/15% w/HSA PrevRx Ω *NEW*	Anthem Silver PPO 2100/30% w/HSA PrevRx Ω,◇	Anthem Silver PPO 2600/35% w/HSA PrevRx Ω,◇
Network (contract code)	Prudent Buyer PPO (6SLF/6SLD) Select PPO (6SLC/6SLE)	Prudent Buyer PPO (6RKO/6RJ5) Select PPO (6RJ2/6RHT)	Prudent Buyer PPO (6RG5/6RH6) Select PPO (6RJM/6RHL)
In-network deductible (individual/family)	\$1,700/\$3,000/\$3,400	\$2,100/\$3,000/\$4,200	\$2,600/\$3,000/\$5,200
Out-of-network deductible (individual/family)	\$3,400/\$6,000/\$6,800	\$4,200/\$6,000/\$8,400	\$5,200/\$6,000/\$10,400
In-network coinsurance	15%	30%	35%
Out-of-network coinsurance	50%	50%	50%
In-network out-of-pocket maximum (individual/family)	\$3,700/\$7,400	\$7,200/\$14,400	\$7,050/\$14,100
Out-of-network out-of-pocket maximum (individual/family)	\$7,400/\$14,800	\$14,400/\$28,800	\$14,100/\$28,200
Office and virtual visits ¹ : Primary care (PCP)/Specialist (SPC)	Deductible, then 15% coinsurance	Deductible, then 30% coinsurance	Deductible, then 35% coinsurance
Virtual doctor visits: Preferred online 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 30% coinsurance	Deductible, then 35% coinsurance
Emergency room (facility)	Deductible, then 15% coinsurance	Deductible, then 30% coinsurance	Deductible, then 35% coinsurance
Independent facility: ambulatory outpatient surgery center	Deductible, then 15% coinsurance	Deductible, then 30% coinsurance	Deductible, then 35% coinsurance
Hospital outpatient surgery facility	Deductible, then \$200 and 15% coinsurance	Deductible, then \$200 and 30% coinsurance	Deductible, then \$200 and 35% coinsurance
Hospital inpatient admission	Deductible, then 15% coinsurance	Deductible, then 30% 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: \$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	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)	\$25/\$90/\$150/30% up to \$250 per script	\$38/\$210/\$330/30% up to \$250 per script	\$38/\$210/\$330/30% 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.

◇ These plans have a different deductible amount if the subscriber is enrolled as self only or has enrolled dependents in the plan. 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.

§ A limited number of benefits use coinsurance - home dialysis, home infusion therapy, diabetic supplies, durable medical equipment (DME) and prosthetics. In plans that have a deductible, these cost shares apply after plan deductible.

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 Anthem Link plans which are covered in full for non-HSA plans and subject to deductible, then covered in full for HSA plans.

2 Cost share applies to virtual visits from our online provider LiveHealth Online (LHO) - urgent/acute medical and behavioral health services (mental health / substance abuse). In addition, free visits for Future Moms Breastfeeding Support and EAP counseling visits on LHO are included with all Anthem medical plans.

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Small Group Employee Elect 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 Ω, †	Anthem Bronze Select PPO 7000/0% w/HSA Ω, †
Network (contract code)	Prudent Buyer PPO (6RJK) Select PPO (6RJU)	Prudent Buyer PPO (6RG7) Select PPO (6RJV)	Select PPO (6RHP)
In-network deductible (individual/family)	\$6,000/\$12,000	\$6,700/\$13,400	\$7,000/\$14,000
Out-of-network deductible (individual/family)	\$12,000/\$24,000	\$13,400/\$26,800	\$14,000/\$28,000
In-network coinsurance	45%	0%	0%
Out-of-network coinsurance	50%	50%	50%
In-network out-of-pocket maximum (individual/family)	\$7,050/\$14,100	\$7,050/\$14,100	\$7,000/\$14,000
Out-of-network out-of-pocket maximum (individual/family)	\$14,100/\$28,200	\$17,625/\$35,250	\$17,500/\$35,000
Office and virtual visits ¹ : Primary care (PCP)/Specialist (SPC)	Deductible, then 45% coinsurance	Deductible, then 0% coinsurance	Deductible, then 0% coinsurance
Virtual doctor visits: Preferred online 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 45% coinsurance	Deductible, then 0% coinsurance	Deductible, then 0% coinsurance
Hospital outpatient surgery facility	Deductible, then \$200 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)	\$50/\$270/\$480/30% up to \$400 per script	\$50/\$270/\$480/30% 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

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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. 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.

§ A limited number of benefits use coinsurance - home dialysis, home infusion therapy, diabetic supplies, durable medical equipment (DME) and prosthetics. In plans that have a deductible, these cost shares apply after plan deductible.

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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 HMO plans

	Platinum plans		
Plan name	Anthem Platinum HMO 0/20 Ω	Anthem Platinum HMO 0/25 Ω	Anthem Platinum HMO 0/30 Ω
Network (contract code)	California Care HMO (6RJ6) Select HMO (6RHH) Priority Select HMO (6RHG)	California Care HMO (6RH3) Select HMO (6RHW) Priority Select HMO (6RG3)	California Care HMO (6RG1) Select HMO (6RGP) Priority Select HMO (6RG4)
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)	\$1,900/\$3,800	\$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 doctor visits: Preferred online provider ²	Covered in full	Covered in full	Covered in full
Urgent care (office)	\$20	\$25	\$30
Emergency room (facility)	\$250	\$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)	\$13/\$60/\$150/30% up to \$250 per script	\$13/\$60/\$150/30% up to \$250 per script	\$13/\$90/\$150/30% 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.

◇ These plans have a different deductible amount if the subscriber is enrolled as self only or has enrolled dependents in the plan. 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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2 Cost share applies to virtual visits from our online provider LiveHealth Online (LHO) - urgent/acute medical and behavioral health services (mental health / substance abuse). In addition, free visits for Future Moms Breastfeeding Support and EAP counseling visits on LHO are included with all Anthem medical plans.

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 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 code)	California Care HMO (6RH8) Select HMO (6RJ4) Priority Select HMO (6RGG)	California Care HMO (6RHZ) Select HMO (6RH0) Priority Select HMO (6RJ3)	California Care HMO (6RGA) Select HMO (6RK2) Priority Select HMO (6RGQ)
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)	\$6,600/\$13,200	\$6,750/\$13,500	\$8,450/\$16,900
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: \$55
Virtual doctor visits: Preferred online 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)	\$25/\$150/\$270/30% up to \$250 per script	\$25/\$150/\$270/30% up to \$250 per script	\$25/\$150/\$270/30% 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.

◇ These plans have a different deductible amount if the subscriber is enrolled as self only or has enrolled dependents in the plan. 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.

§ A limited number of benefits use coinsurance - home dialysis, home infusion therapy, diabetic supplies, durable medical equipment (DME) and prosthetics. In plans that have a deductible, these cost shares apply after plan deductible.

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2 Cost share applies to virtual visits from our online provider LiveHealth Online (LHO) - urgent/acute medical and behavioral health services (mental health / substance abuse). In addition, free visits for Future Moms Breastfeeding Support and EAP counseling visits on LHO are included with all Anthem medical plans.

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 Employee Elect product details – groups of 1 to 100 employees

Anthem HMO plans

	Gold plans		
Plan name	Anthem Gold HMO 35/500/20% RxD Ω *NEW*	Anthem Gold HMO 35/1250/20% Ω	Anthem Gold HMO 35/1250/20% RxD Ω *NEW*
Network (contract code)	California Care HMO (8NAF) Select HMO (8NAE) Priority Select HMO (8NAN)	California Care HMO (6RHC) Select HMO (6RJW) Priority Select HMO (6RGO)	California Care HMO (8NAM) Select HMO (8NAK) Priority Select HMO (8NAJ)
In-network deductible (individual/family)	\$500/\$1,500	\$1,250/\$2,500	\$1,250/\$2,500
Out-of-network deductible (individual/family)	Not applicable	Not applicable	Not applicable
In-network coinsurance	20%	20%	20%
Out-of-network coinsurance	Not applicable	Not applicable	Not applicable
In-network out-of-pocket maximum (individual/family)	\$8,450/\$16,900	\$8,600/\$17,200	\$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: \$35 SPC: \$55	PCP: \$35 SPC: \$60	PCP: \$35 SPC: \$60
Virtual doctor visits: Preferred online provider ²	Covered in full	Covered in full	Covered in full
Urgent care (office)	\$35	\$35	\$35
Emergency room (facility)	Deductible, then \$300 and 20% coinsurance	Deductible, then \$300 and 20% coinsurance	Deductible, then \$300 and 20% coinsurance
Independent facility: ambulatory outpatient surgery center	Deductible, then \$500	Deductible, then \$500	Deductible, then \$500
Hospital outpatient surgery facility	Deductible, then 20% coinsurance	Deductible, then 20% coinsurance	Deductible, then 20% coinsurance
Hospital inpatient admission	Deductible, then 20% coinsurance	Deductible, then 20% 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)	Tier 1: No deductible Tiers 2-4: \$150/\$300 Pharmacy deductible	Tiers 1-4: No deductible	Tier 1: No deductible Tiers 2-4: \$150/\$300 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)	\$25/\$150/\$270/30% up to \$250 per script	\$25/\$150/\$270/30% up to \$250 per script	\$25/\$150/\$270/30% 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.

◇ These plans have a different deductible amount if the subscriber is enrolled as self only or has enrolled dependents in the plan. 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.

§ A limited number of benefits use coinsurance - home dialysis, home infusion therapy, diabetic supplies, durable medical equipment (DME) and prosthetics. In plans that have a deductible, these cost shares apply after plan deductible.

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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 Employee Elect product details – groups of 1 to 100 employees

Anthem HMO plans

	Silver plans	
Plan name	Anthem Silver HMO 55 Ω	Anthem Silver HMO 60/2500/45% Ω
Network (contract code)	California Care HMO (6RJG) Select HMO (6RHQ) Priority Select HMO (6RK5)	California Care HMO (6RHM) Select HMO (6RHB) Priority Select HMO (6RFS)
In-network deductible (individual/family)	\$0/\$0	\$2,500/\$5,000
Out-of-network deductible (individual/family)	Not applicable	Not applicable
In-network coinsurance	0%	45%
Out-of-network coinsurance	Not applicable	Not applicable
In-network out-of-pocket maximum (individual/family)	\$9,100/\$18,200	\$9,100/\$18,200
Out-of-network out-of-pocket maximum (individual/family)	Not applicable	Not applicable
Office and virtual visits ¹ : Primary care (PCP)/Specialist (SPC)	PCP: \$55 SPC: \$110	PCP: \$60 SPC: \$110
Virtual doctor visits: Preferred online provider ²	Covered in full	Covered in full
Urgent care (office)	\$55	\$60
Emergency room (facility)	\$500	Deductible, then \$350 and 45% coinsurance
Independent facility: ambulatory outpatient surgery center	\$550	Deductible, then \$600
Hospital outpatient surgery facility	\$600	Deductible, then 45% coinsurance
Hospital inpatient admission	\$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
Pharmacy deductible ³ (individual/family)	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: \$20/\$95/\$150/30% up to \$250 per script Level 2: \$30/\$105/\$160/40% 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)	\$50/\$285/\$450/30% up to \$250 per script	\$38/\$210/\$330/30% 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

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. 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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§ A limited number of benefits use coinsurance – home dialysis, home infusion therapy, diabetic supplies, durable medical equipment (DME) and prosthetics. In plans that have a deductible, these cost shares apply after plan deductible.

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Small Group Employee Elect product details – groups of 1 to 100 employees

Anthem Link Vivity HMO plans

	Platinum plans	Gold plans	
Plan name	Anthem Link Platinum Vivity HMO 15	Anthem Link Gold Vivity HMO 25	Anthem Link Gold Vivity HMO 25/500
Network (contract code)	Vivity (6RG8)	Vivity (6RJZ)	Vivity (6RHV)
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	Limited \$	Limited \$	Limited \$
Out-of-network coinsurance	Not applicable	Not applicable	Not applicable
In-network out-of-pocket maximum (individual/family)	\$2,500/\$5,000	\$6,150/\$12,300	\$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 doctor visits: Preferred online 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 1-2: No deductible Tiers 3-4: 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/\$50/\$125/\$250 Level 2: \$20/\$60/\$135/\$250	Level 1: \$10/\$50/\$125/\$250 Level 2: \$20/\$60/\$135/\$250
Home delivery pharmacy ⁴ (tier 1/tier 2/tier 3/tier 4)	\$13/\$75/\$225/\$250	\$25/\$150/\$375/\$250	\$25/\$150/\$375/\$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

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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. 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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Small Group Employee Elect product details – groups of 1 to 100 employees

Anthem Link Vivity HMO plans

	Gold plans		Silver plans
Plan name	Anthem Link Gold Vivity HMO 35/1000	Anthem Link Gold Vivity HMO 35/1850	Anthem Link Silver Vivity HMO 50/2650
Network (contract code)	Vivity (6RGJ)	Vivity (6RK7)	Vivity (6RG2)
In-network deductible (individual/family)	\$1,000/\$2,000	\$1,850/\$3,700	\$2,650/\$5,300
Out-of-network deductible (individual/family)	Not applicable	Not applicable	Not applicable
In-network coinsurance	Limited \$	Limited \$	Limited \$
Out-of-network coinsurance	Not applicable	Not applicable	Not applicable
In-network out-of-pocket maximum (individual/family)	\$6,750/\$13,500	\$7,750/\$15,500	\$9,100/\$18,200
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: \$35 SPC: \$75	PCP: \$35 SPC: \$75	PCP: \$50 SPC: \$110
Virtual doctor visits: Preferred online provider ²	Covered in full	Covered in full	Covered in full
Urgent care (office)	\$35	\$35	\$50
Emergency room (facility)	Deductible, then \$500	Deductible, then \$500	Deductible, then \$500
Independent facility: ambulatory outpatient surgery center	Deductible, then \$500	Deductible, then \$500	Deductible, then \$1,000
Hospital outpatient surgery facility	Deductible, then \$500	Deductible, then \$500	Deductible, then \$1,000
Hospital inpatient admission	Deductible, then \$750 per admission	Deductible, then \$750 per admission	Deductible, then \$1,500 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 1-2: No deductible Tiers 3-4: Medical deductible applies	Tiers 1-2: No deductible Tiers 3-4: Medical deductible applies	Tiers 1-2: No deductible Tiers 3-4: Medical deductible applies
Retail pharmacy: 30-day supply (tier 1/tier 2/tier 3/tier 4)	Level 1: \$10/\$50/\$125/\$250 Level 2: \$20/\$60/\$135/\$250	Level 1: \$10/\$50/\$125/\$250 Level 2: \$20/\$60/\$135/\$250	Level 1: \$20/\$95/\$150/\$250 Level 2: \$25/\$105/\$160/\$250
Home delivery pharmacy ⁴ (tier 1/tier 2/tier 3/tier 4)	\$25/\$150/\$375/\$250	\$25/\$150/\$375/\$250	\$50/\$285/\$450/\$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

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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 Employee Elect 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 code)	Prudent Buyer PPO (6RFQ)	Prudent Buyer PPO (6RJA)	Prudent Buyer PPO (6RK3)
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)	\$3,800/\$7,600	\$8,200/\$16,400	\$8,200/\$16,400
Out-of-network out-of-pocket maximum (individual/family)	\$7,600/\$15,200	\$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 doctor visits: Preferred online 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 15% coinsurance	Deductible, then 25% coinsurance	Deductible, then 20% coinsurance
Hospital outpatient surgery facility	Deductible, then \$200 and 15% coinsurance	Deductible, then \$200 and 25% coinsurance	Deductible, then \$200 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)	\$13/\$90/\$150/30% up to \$250 per script	\$25/\$150/\$270/30% up to \$250 per script	\$13/\$180/\$330/30% 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

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. 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.

§ A limited number of benefits use coinsurance - home dialysis, home infusion therapy, diabetic supplies, durable medical equipment (DME) and prosthetics. In plans that have a deductible, these cost shares apply after plan deductible.

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 Anthem Link plans which are covered in full for non-HSA plans and subject to deductible, then covered in full for HSA plans.

2 Cost share applies to virtual visits from our online provider LiveHealth Online (LHO) - urgent/acute medical and behavioral health services (mental health / substance abuse). In addition, free visits for Future Moms Breastfeeding Support and EAP counseling visits on LHO are included with all Anthem medical plans.

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Small Group Employee Elect 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 code)	Prudent Buyer PPO (6RGZ) Select PPO (6RJE)	Prudent Buyer PPO (6RGE)
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 doctor visits: Preferred online 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 40% coinsurance	Deductible, then 45% coinsurance
Hospital outpatient surgery facility	Deductible, then \$250 and 40% coinsurance	Deductible, then \$200 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)	\$38/\$210/\$330/30% up to \$250 per script	\$38/\$210/\$330/30% 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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Small Group Employee Elect 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 Ω, †
Network (contract code)	Prudent Buyer PPO (6RGR)	Prudent Buyer PPO (6RJB)
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)	\$7,050/\$14,100	\$7,050/\$14,100
Out-of-network out-of-pocket maximum (individual/family)	\$14,100/\$28,200	\$17,625/\$35,250
Office and virtual visits ¹ : Primary care (PCP)/Specialist (SPC)	Deductible, then 45% coinsurance	Deductible, then 0% coinsurance
Virtual doctor visits: Preferred online 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 45% coinsurance	Deductible, then 0% coinsurance
Hospital outpatient surgery facility	Deductible, then \$200 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)	\$50/\$270/\$480/30% up to \$400 per script	\$50/\$270/\$480/30% 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. 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 to 100 employees

Anthem HMO Whole Health plans

	Silver plans
Plan name	Anthem Silver Select HMO 60/2500/45% WH Ω *NEW*
Network (contract code)	Select HMO (6RFX) Priority Select HMO (6RJH)
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)	\$9,100/\$18,200
Out-of-network out-of-pocket maximum (individual/family)	Not applicable
Office and virtual visits ¹ : Primary care (PCP)/Specialist (SPC)	PCP: \$60 SPC: \$110
Virtual doctor visits: Preferred online provider ²	Covered in full
Urgent care (office)	\$60
Emergency room (facility)	Deductible, then \$350 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: \$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)	\$38/\$210/\$330/30% 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. 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.

§ A limited number of benefits use coinsurance – home dialysis, home infusion therapy, diabetic supplies, durable medical equipment (DME) and prosthetics. In plans that have a deductible, these cost shares apply after plan deductible.

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 Anthem Link plans which are covered in full for non-HSA plans and subject to deductible, then covered in full for HSA plans.

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

Anthem Link Vivity HMO Whole Health plans

	Platinum plans	Gold plans	
Plan name	Anthem Link Platinum Vivity HMO 15 WH	Anthem Link Gold Vivity HMO 25 WH	Anthem Link Gold Vivity HMO 25/500 WH
Network (contract code)	Vivity (6RGN)	Vivity (6RJR)	Vivity (6RGL)
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	Limited \$	Limited \$	Limited \$
Out-of-network coinsurance	Not applicable	Not applicable	Not applicable
In-network out-of-pocket maximum (individual/family)	\$2,500/\$5,000	\$6,150/\$12,300	\$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 doctor visits: Preferred online 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 1-2: No deductible Tiers 3-4: 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/\$50/\$125/\$250 Level 2: \$20/\$60/\$135/\$250	Level 1: \$10/\$50/\$125/\$250 Level 2: \$20/\$60/\$135/\$250
Home delivery pharmacy ⁴ (tier 1/tier 2/tier 3/tier 4)	\$13/\$75/\$225/\$250	\$25/\$150/\$375/\$250	\$25/\$150/\$375/\$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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- ◇ These plans have a different deductible amount if the subscriber is enrolled as self only or has enrolled dependents in the plan. 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.
- § A limited number of benefits use coinsurance – home dialysis, home infusion therapy, diabetic supplies, durable medical equipment (DME) and prosthetics. In plans that have a deductible, these cost shares apply after plan deductible.
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Small Group Employee Elect product details – groups of 1 to 100 employees

Anthem Link Vivity HMO Whole Health plans

	Gold plans		Silver plans
Plan name	Anthem Link Gold Vivity HMO 35/1000 WH	Anthem Link Gold Vivity HMO 35/1850 WH	Anthem Link Silver Vivity HMO 50/2650 WH
Network (contract code)	Vivity (6RFW)	Vivity (6RGM)	Vivity (6RFZ)
In-network deductible (individual/family)	\$1,000/\$2,000	\$1,850/\$3,700	\$2,650/\$5,300
Out-of-network deductible (individual/family)	Not applicable	Not applicable	Not applicable
In-network coinsurance	Limited \$	Limited \$	Limited \$
Out-of-network coinsurance	Not applicable	Not applicable	Not applicable
In-network out-of-pocket maximum (individual/family)	\$6,750/\$13,500	\$7,750/\$15,500	\$9,100/\$18,200
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: \$35 SPC: \$75	PCP: \$35 SPC: \$75	PCP: \$50 SPC: \$110
Virtual doctor visits: Preferred online provider ²	Covered in full	Covered in full	Covered in full
Urgent care (office)	\$35	\$35	\$50
Emergency room (facility)	Deductible, then \$500	Deductible, then \$500	Deductible, then \$500
Independent facility: ambulatory outpatient surgery center	Deductible, then \$500	Deductible, then \$500	Deductible, then \$1,000
Hospital outpatient surgery facility	Deductible, then \$500	Deductible, then \$500	Deductible, then \$1,000
Hospital inpatient admission	Deductible, then \$750 per admission	Deductible, then \$750 per admission	Deductible, then \$1,500 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 1-2: No deductible Tiers 3-4: Medical deductible applies	Tiers 1-2: No deductible Tiers 3-4: Medical deductible applies	Tiers 1-2: No deductible Tiers 3-4: Medical deductible applies
Retail pharmacy: 30-day supply (tier 1/tier 2/tier 3/tier 4)	Level 1: \$10/\$50/\$125/\$250 Level 2: \$20/\$60/\$135/\$250	Level 1: \$10/\$50/\$125/\$250 Level 2: \$20/\$60/\$135/\$250	Level 1: \$20/\$95/\$150/\$250 Level 2: \$25/\$105/\$160/\$250
Home delivery pharmacy ⁴ (tier 1/tier 2/tier 3/tier 4)	\$25/\$150/\$375/\$250	\$25/\$150/\$375/\$250	\$50/\$285/\$450/\$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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MOVING FORWARD, TOGETHER

Delivering the future of healthcare, today

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.

We're here to help. Call your Anthem representative.

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