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Plan Name	Anthem Platinum EPO 5/25 0%	Anthem Platinum Blue Access EPO 5/25 0%	Anthem Platinum EPO 20/40 0%	Anthem Platinum Blue Access EPO 20/40 0%
Contract Code	9B6V	9TUM	9B6L	9TUN
Premium				
Individual	$1,151.36	$1,056.32	$1,141.69	$1,047.42
Individual + Spouse	$2,302.72	$2,112.64	$2,283.38	$2,094.84
Individual + Child(ren)	$1,957.31	$1,795.74	$1,940.87	$1,780.61
Family	$3,281.38	$3,010.51	$3,253.82	$2,985.15

Plan Name	Anthem Platinum EPO 5/25 0% WH	Anthem Platinum Blue Access EPO 5/25 0% WH	Anthem Platinum EPO 20/40 0% WH	Anthem Platinum Blue Access EPO 20/40 0% WH
Contract Code	9Y7T	9TUK	9B6X	9B6C
Enhanced Embedded Dental and Vision Premium				
Individual	$1,170.50	$1,074.02	$1,160.73	$1,065.12
Individual + Spouse	$2,341.00	$2,148.04	$2,321.46	$2,130.24
Individual + Child(ren)	$1,989.85	$1,825.83	$1,973.24	$1,810.70
Family	$3,335.93	$3,060.96	$3,308.08	$3,035.59
Plan Details				
Network	PPO/EPO	Blue Access	PPO/EPO	Blue Access
National Access via Bluecard Program	Full Access	Full Access	Full Access	Full Access
Gatekeeper	No	No	No	No
Rx Network	Base with R90	Base with R90	Base with R90	Base with R90
Formulary	Traditional Open	Traditional Open	Traditional Open	Traditional Open
Creditability Coverage Status	Pass	Pass	Pass	Pass
Embedded / Non-Embedded Medical Deductible	Embedded	Embedded	Embedded	Embedded
Plan Benefits				
INN Deductible (Ind / Fam)	$0/$0	$0/$0	$0/$0	$0/$0
OON Deductible (Ind / Fam)	-	-	-	-
INN Coinsurance	0%	0%	0%	0%
OON Coinsurance	-	-	-	-
INN Out of Pocket Max (Ind / Fam)	$3,700/$7,400	$3,700/$7,400	$3,000/$6,000	$3,000/$6,000
OON Out of Pocket Max (Ind / Fam)	-	-	-	-
Preferred Virtual PCP: TeleHealth & Medical Chat via KHealth/LHO	$0	$0	$0	$0
Primary Care Visit	$5	$5	$20	$20
Specialist Visit	$25	$25	$40	$40
Emergency Room	$300	$300	$300	$300
Urgent Care	$75	$75	$50	$50
Inpatient Facility	$400	$400	$500	$500
Ambulatory Surgical Center/Outpatient Facility Surgery	$50/$300	$50/$300	$50/$500	$50/$500
Preferred Lab / Preferred Office Lab	$0	$0	$0	$0
INN Lab (Office; Outpatient Hospital)	$0/$0	$0/$0	$0/$0	$0/$0
INN X-Ray (Office; Outpatient Hospital)	$50/$150	$50/$150	$50/$150	$50/$150
INN Adv Diagnostic Imaging (Office; Outpatient Hospital)	$150/$250	$150/$250	$150/$250	$150/$250
Rx Deductible	Tiers 2 & 3, $100/$200	Tiers 2 & 3, $100/$200	Tiers 2 & 3, $100/$200	Tiers 2 & 3, $100/$200
Rx Copay (Tier 1 / 2 / 3)	$10/$35/$70	$10/$35/$70	$10/$35/$70	$10/$35/$70

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Plan Name	Anthem Platinum Blue Access EPO 15/35 300 10%	Anthem Gold EPO 25/50 0%	Anthem Gold Blue Access EPO 25/50 0%	Anthem Gold EPO 50/55 1000 10%
Contract Code	9B6K	9B6M	A7N0	9B6N
Premium				
Individual	$1,029.42	$1,039.57	$953.82	$989.23
Individual + Spouse	$2,058.84	$2,079.14	$1,907.64	$1,978.46
Individual + Child(ren)	$1,750.01	$1,767.27	$1,621.49	$1,681.69
Family	$2,933.85	$2,962.77	$2,718.39	$2,819.31

Plan Name	Anthem Platinum Blue Access EPO 15/35 300 10% WH	Anthem Gold EPO 25/50 0% WH	Anthem Gold Blue Access EPO 25/50 0% WH	Anthem Gold EPO 50/55 1000 10% WH
Contract Code	9TUJ	9B6D	A7N2	9B6H
Enhanced Embedded Dental and Vision Premium				
Individual	$1,047.32	$1,058.71	$968.84	$1,008.56
Individual + Spouse	$2,094.64	$2,117.42	$1,937.68	$2,017.12
Individual + Child(ren)	$1,780.44	$1,799.81	$1,647.03	$1,714.55
Family	$2,984.86	$3,017.32	$2,761.19	$2,874.40
Plan Details				
Network	Blue Access	PPO/EPO	Blue Access	PPO/EPO
National Access via Bluecard Program	Full Access	Full Access	Full Access	Full Access
Gatekeeper	No	No	No	No
Rx Network	Base with R90	Base with R90	Base with R90	Base with R90
Formulary	Traditional Open	Traditional Open	Traditional Open	Traditional Open
Creditability Coverage Status	Pass	Pass	Pass	Pass
Embedded / Non-Embedded Medical Deductible	Embedded	Embedded	Embedded	Embedded
Plan Benefits				
INN Deductible (Ind / Fam)	$300/$600	$0/$0	$0/$0	$1,000/$2,000
OON Deductible (Ind / Fam)	-	-	-	-
INN Coinsurance	10%	0%	0%	10%
OON Coinsurance	-	-	-	-
INN Out of Pocket Max (Ind / Fam)	$3,200/$6,400	$8,700/$17,400	$8,700/$17,400	$7,000/$14,000
OON Out of Pocket Max (Ind / Fam)	-	-	-	-
Preferred Virtual PCP: TeleHealth & Medical Chat via KHealth/LHO	$0	$0	$0	$0
Primary Care Visit	$15	$25	$25	$50
Specialist Visit	$35	$50	$50	$55
Emergency Room	Ded, then 10%	$750	$750	Ded, then $500 Copay
Urgent Care	$50	$50	$50	$60
Inpatient Facility	Ded, then 10%	$500	$500	Ded, then 10%
Ambulatory Surgical Center/Outpatient Facility Surgery	Ded, then $50 Copay/Ded, then 10%	$150/$500	$150/$500	Ded, then $150 Copay/Ded, then $300 Copay
Preferred Lab / Preferred Office Lab	$0	$0	$0	$0
INN Lab (Office; Outpatient Hospital)	$20/$25	$0/$0	$0/$0	$0/$0
INN X-Ray (Office; Outpatient Hospital)	Ded, then $75 Copay/Ded, then 10%	$50/$150	$50/$150	Ded, then $50 Copay/Ded, then $150 Copay
INN Adv Diagnostic Imaging (Office; Outpatient Hospital)	Ded, then $150 Copay/Ded, then 10%	$150/$250	$150/$250	Ded, then $150 Copay/Ded, then $250 Copay
Rx Deductible	Tiers 2 & 3, $100/$200	Tiers 2 & 3, $150/$300	Tiers 2 & 3, $150/$300	Tiers 2 & 3, $150/$300
Rx Copay (Tier 1 / 2 / 3)	$10/$35/$70	$10/$40/$90	$10/$40/$90	$10/$40/$80

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Plan Name	Anthem Gold Blue Access EPO 50/55 1000 0%	Anthem Gold EPO 20/50 1600 10% w/HSA	Anthem Gold Blue Access EPO 20/50 1600 10% w/HSA	Anthem Gold EPO 15/35 1750 10%
Contract Code	A7MY	A7MZ	A7DQ	9B6Y
Premium				
Individual	$921.85	$950.18	$871.79	$972.38
Individual + Spouse	$1,843.70	$1,900.36	$1,743.58	$1,944.76
Individual + Child(ren)	$1,567.15	$1,615.31	$1,482.04	$1,653.05
Family	$2,627.27	$2,708.01	$2,484.60	$2,771.28

Plan Name	Anthem Gold Blue Access EPO 50/55 1000 0% WH	Anthem Gold EPO 20/50 1600 10% w/HSA WH	Anthem Gold Blue Access EPO 20/50 1600 10% w/HSA WH	Anthem Gold EPO 15/35 1750 10% WH
Contract Code	9B6T	9B6G	A7DS	A7MX
Enhanced Embedded Dental and Vision Premium				
Individual	$939.75	$969.51	$889.69	$991.72
Individual + Spouse	$1,879.50	$1,939.02	$1,779.38	$1,983.44
Individual + Child(ren)	$1,597.58	$1,648.17	$1,512.47	$1,685.92
Family	$2,678.29	$2,763.10	$2,535.62	$2,826.40
Plan Details				
Network	Blue Access	PPO/EPO	Blue Access	PPO/EPO
National Access via Bluecard Program	Full Access	Full Access	Full Access	Full Access
Gatekeeper	No	No	No	No
Rx Network	Base with R90	Base with R90	Base with R90	Base with R90
Formulary	Traditional Open	Traditional Open	Traditional Open	Traditional Open
Creditability Coverage Status	Pass	Pass	Pass	Pass
Embedded / Non-Embedded Medical Deductible	Embedded	Non-Embedded	Non-Embedded	Embedded
Plan Benefits				
INN Deductible (Ind / Fam)	$1,000/$2,000	$1,600/$3,200	$1,600/$3,200	$1,750/$3,500
OON Deductible (Ind / Fam)	-	-	-	-
INN Coinsurance	0%	10%	10%	10%
OON Coinsurance	-	-	-	-
INN Out of Pocket Max (Ind / Fam)	$7,000/$14,000	$5,100/$10,200	$5,100/$10,200	$8,700/$17,400
OON Out of Pocket Max (Ind / Fam)	-	-	-	-
Preferred Virtual PCP: TeleHealth & Medical Chat via KHealth/LHO	$0	Ded, then $0	Ded, then $0	$0
Primary Care Visit	$50	Ded, then $20 Copay	Ded, then $20 Copay	$15
Specialist Visit	$55	Ded, then $50 Copay	Ded, then $50 Copay	$35
Emergency Room	Ded, then $500 Copay	Ded, then $500 Copay	Ded, then $500 Copay	Ded, then $750 Copay
Urgent Care	$60	Ded, then $100 Copay	Ded, then $100 Copay	$60
Inpatient Facility	Ded, then $500 Copay	Ded, then $1,000 Copay	Ded, then $1,000 Copay	Ded, then 10%
Ambulatory Surgical Center/Outpatient Facility Surgery	Ded, then $150 Copay/Ded, then $300 Copay	Ded, then $300 Copay/Ded, then $500 Copay	Ded, then $300 Copay/Ded, then $500 Copay	Ded, then $150 Copay/Ded, then $300 Copay
Preferred Lab / Preferred Office Lab	$0	Ded, then $0	Ded, then $0	$0
INN Lab (Office; Outpatient Hospital)	$0/$0	Ded, then $25 Copay/Ded, then $25 Copay	Ded, then $25 Copay/Ded, then $25 Copay	$0/$0
INN X-Ray (Office; Outpatient Hospital)	Ded, then $50 Copay/Ded, then $150 Copay	Ded, then $50 Copay/Ded, then $150 Copay	Ded, then $50 Copay/Ded, then $150 Copay	Ded, then $50 Copay/Ded, then $150 Copay
INN Adv Diagnostic Imaging (Office; Outpatient Hospital)	Ded, then $150 Copay/Ded, then $250 Copay	Ded, then $150 Copay/Ded, then $250 Copay	Ded, then $150 Copay/Ded, then $250 Copay	Ded, then $150 Copay/Ded, then $250 Copay
Rx Deductible	Tiers 2 & 3, $150/$300	Med Ded	Med Ded	Tiers 2 & 3, $150/$300
Rx Copay (Tier 1 / 2 / 3)	$10/$40/$80	$10/$40/$80	$10/$40/$80	$10/$40/$80

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Plan Name	Anthem Gold Blue Access EPO 15/35 1750 10%	Anthem Gold EPO 25/45 1850 20%	Anthem Gold Blue Access EPO 25/45 1850 20%	Anthem Gold Healthy New York Blue Access GEPO 25/40 600 0%
Contract Code	A7DW	A7N1	9B6W	9TUL
Premium				
Individual	$892.08	$965.40	$885.77	$742.69
Individual + Spouse	$1,784.16	$1,930.80	$1,771.54	$1,485.38
Individual + Child(ren)	$1,516.54	$1,641.18	$1,505.81	$1,262.57
Family	$2,542.43	$2,751.39	$2,524.44	$2,116.67

Plan Name	Anthem Gold Blue Access EPO 15/35 1750 10% WH	Anthem Gold EPO 25/45 1850 20% WH	Anthem Gold Blue Access EPO 25/45 1850 20% WH	Not Offered
Contract Code	A7DV	9B6A	9B6J	
Enhanced Embedded Dental and Vision Premium				
Individual	$910.08	$984.82	$903.76	
Individual + Spouse	$1,820.16	$1,969.64	$1,807.52	
Individual + Child(ren)	$1,547.14	$1,674.19	$1,536.39	
Family	$2,593.73	$2,806.74	$2,575.72	
Plan Details				
Network	Blue Access	PPO/EPO	Blue Access	Blue Access
National Access via Bluecard Program	Full Access	Full Access	Full Access	Full Access
Gatekeeper	No	No	No	Yes
Rx Network	Base with R90	Base with R90	Base with R90	Base with R90
Formulary	Traditional Open	Traditional Open	Traditional Open	Select
Creditability Coverage Status	Pass	Pass	Pass	Pass
Embedded / Non-Embedded Medical Deductible	Embedded	Embedded	Embedded	Embedded
Plan Benefits				
INN Deductible (Ind / Fam)	$1,750/$3,500	$1,850/$3,700	$1,850/$3,700	$600/$1,200
OON Deductible (Ind / Fam)	-	-	-	-
INN Coinsurance	10%	20%	20%	0%
OON Coinsurance	-	-	-	-
INN Out of Pocket Max (Ind / Fam)	$8,700/$17,400	$6,500/$13,000	$6,500/$13,000	$5,900/$11,800
OON Out of Pocket Max (Ind / Fam)	-	-	-	-
Preferred Virtual PCP: TeleHealth & Medical Chat via KHealth/LHO	$0	$0	$0	$0/Ded, then $25 Copay
Primary Care Visit	$15	$25	$25	Ded, then $25 Copay
Specialist Visit	$35	$45	$45	Ded, then $40 Copay
Emergency Room	Ded, then $750 Copay	Ded, then $750 Copay	Ded, then $750 Copay	Ded, then $150 Copay
Urgent Care	$60	$60	$60	Ded, then $60 Copay
Inpatient Facility	Ded, then 10%	Ded, then 20%	Ded, then 20%	Ded, then $1,000 Copay
Ambulatory Surgical Center/Outpatient Facility Surgery	Ded, then $150 Copay/Ded, then $300 Copay	Ded, then $150 Copay/Ded, then $500 Copay	Ded, then $150 Copay/Ded, then $500 Copay	Ded, then $100 Copay
Preferred Lab / Preferred Office Lab	$0	$0	$0	Ded, then $25 Copay
INN Lab (Office; Outpatient Hospital)	$0/$0	$0/$0	$0/$0	Ded, then $25 Copay/Ded, then $40 Copay
INN X-Ray (Office; Outpatient Hospital)	Ded, then $50 Copay/Ded, then $150 Copay	Ded, then $50 Copay/Ded, then $150 Copay	Ded, then $50 Copay/Ded, then $150 Copay	Ded, then $25 Copay/Ded, then $40 Copay
INN Adv Diagnostic Imaging (Office; Outpatient Hospital)	Ded, then $150 Copay/Ded, then $250 Copay	Ded, then $150 Copay/Ded, then $250 Copay	Ded, then $150 Copay/Ded, then $250 Copay	Ded, then $40 Copay/Ded, then $40 Copay
Rx Deductible	Tiers 2 & 3, $150/$300	Tiers 2 & 3, $150/$300	Tiers 2 & 3, $150/$300	NA
Rx Copay (Tier 1 / 2 / 3)	$10/$40/$80	$10/$50/$90	$10/$50/$90	$10/$35/$70

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Plan Name	Anthem Silver Blue Access EPO 60/125 0%	Anthem Silver EPO 40/70 2600 30%	Anthem Silver Blue Access EPO 40/70 2600 30%	Anthem Silver EPO 20/50 3250 25% w/HSA
Contract Code	A2TW	A2TX	9Y7U	A2U2
Premium				
Individual	$844.42	$869.40	$797.72	$844.14
Individual + Spouse	$1,688.84	$1,738.80	$1,595.44	$1,688.28
Individual + Child(ren)	$1,435.51	$1,477.98	$1,356.12	$1,435.04
Family	$2,406.60	$2,477.79	$2,273.50	$2,405.80

Plan Name	Anthem Silver Blue Access EPO 60/125 0% WH	Anthem Silver EPO 40/70 2600 30% WH	Anthem Silver Blue Access EPO 40/70 2600 30% WH	Anthem Silver EPO 20/50 3250 25% w/HSA WH
Contract Code	9B68	A2TZ	9B6S	A2TY
Enhanced Embedded Dental and Vision Premium				
Individual	$862.03	$888.93	$815.71	$863.66
Individual + Spouse	$1,724.06	$1,777.86	$1,631.42	$1,727.32
Individual + Child(ren)	$1,465.45	$1,511.18	$1,386.71	$1,468.22
Family	$2,456.79	$2,533.45	$2,324.77	$2,461.43
Plan Details				
Network	Blue Access	PPO/EPO	Blue Access	PPO/EPO
National Access via Bluecard Program	Full Access	Full Access	Full Access	Full Access
Gatekeeper	No	No	No	No
Rx Network	Base with R90	Base with R90	Base with R90	Base with R90
Formulary	Traditional Open	Traditional Open	Traditional Open	Traditional Open
Creditability Coverage Status	Pass	Pass	Pass	Pass
Embedded / Non-Embedded Medical Deductible	Embedded	Embedded	Embedded	Embedded
Plan Benefits				
INN Deductible (Ind / Fam)	$0/$0	$2,600/$5,200	$2,600/$5,200	$3,250/$6,500
OON Deductible (Ind / Fam)	-	-	-	-
INN Coinsurance	0%	30%	30%	25%
OON Coinsurance	-	-	-	-
INN Out of Pocket Max (Ind / Fam)	$9,450/$18,900	$9,450/$18,900	$9,450/$18,900	$8,000/$16,000
OON Out of Pocket Max (Ind / Fam)	-	-	-	-
Preferred Virtual PCP: TeleHealth & Medical Chat via KHealth/LHO	$0	$0	$0	Ded, then $0
Primary Care Visit	$60	$40	$40	Ded, then $20 Copay
Specialist Visit	$125	$70	$70	Ded, then $50 Copay
Emergency Room	$2,800	Ded, then $500 Copay	Ded, then $500 Copay	Ded, then $500 Copay
Urgent Care	$125	$75	$75	Ded, then $100 Copay
Inpatient Facility	$2,800	Ded, then 30%	Ded, then 30%	Ded, then $1,500 Copay
Ambulatory Surgical Center/Outpatient Facility Surgery	$500/$1,000	Ded, then $150 Copay/Ded, then $300 Copay	Ded, then $150 Copay/Ded, then $300 Copay	Ded, then $300 Copay/Ded, then $500 Copay
Preferred Lab / Preferred Office Lab	$0	$0	$0	Ded, then $0
INN Lab (Office; Outpatient Hospital)	$60/$20	$0/$0	$0/$0	Ded, then $25 Copay/Ded, then $25 Copay
INN X-Ray (Office; Outpatient Hospital)	$150/$150	Ded, then $50 Copay/Ded, then $150 Copay	Ded, then $50 Copay/Ded, then $150 Copay	Ded, then $50 Copay/Ded, then $150 Copay
INN Adv Diagnostic Imaging (Office; Outpatient Hospital)	$250/$250	Ded, then $150 Copay/Ded, then $250 Copay	Ded, then $150 Copay/Ded, then $250 Copay	Ded, then $150 Copay/Ded, then $250 Copay
Rx Deductible	NA	Tiers 2 & 3, $200/$400	Tiers 2 & 3, $200/$400	Med Ded
Rx Copay (Tier 1 / 2 / 3)	$15/$65/$95	$35/$70/$100	$35/$70/$100	$10/$50/$90

1) Anthem Blue Cross is the trade name of Anthem HealthChoice HMO, Inc. and Anthem HealthChoice Assurance, Inc. Anthem Blue Cross HP is the trade name of Anthem HP, LLC. Independent licensees of the Blue Cross and Blue Shield Association. Anthem is a registered trademark of Anthem Insurance Companies, Inc.

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Plan Name	Anthem Silver Blue Access EPO 20/50 3250 25% w/HSA	Anthem Silver EPO 40/80 3250 50%	Anthem Silver Blue Access EPO 40/80 3250 50%	Anthem Silver EPO 20/50 4000 30% w/HSA
Contract Code	9Y7S	9B67	9B6Z	9B6P
Premium				
Individual	$774.46	$833.70	$764.89	$822.60
Individual + Spouse	$1,548.92	$1,667.40	$1,529.78	$1,645.20
Individual + Child(ren)	$1,316.58	$1,417.29	$1,300.31	$1,398.42
Family	$2,207.21	$2,376.05	$2,179.94	$2,344.41

Plan Name	Anthem Silver Blue Access EPO 20/50 3250 25% w/HSA WH	Anthem Silver EPO 40/80 3250 50% WH	Anthem Silver Blue Access EPO 40/80 3250 50% WH	Anthem Silver EPO 20/50 4000 30% w/HSA WH
Contract Code	9Y7P	A2U1	9Y7V	A2U0
Enhanced Embedded Dental and Vision Premium				
Individual	$792.55	$853.13	$782.98	$842.13
Individual + Spouse	$1,585.10	$1,706.26	$1,565.96	$1,684.26
Individual + Child(ren)	$1,347.34	$1,450.32	$1,331.07	$1,431.62
Family	$2,258.77	$2,431.42	$2,231.49	$2,400.07
Plan Details				
Network	Blue Access	PPO/EPO	Blue Access	PPO/EPO
National Access via Bluecard Program	Full Access	Full Access	Full Access	Full Access
Gatekeeper	No	No	No	No
Rx Network	Base with R90	Base with R90	Base with R90	Base with R90
Formulary	Traditional Open	Traditional Open	Traditional Open	Traditional Open
Creditability Coverage Status	Pass	Pass	Pass	Pass
Embedded / Non-Embedded Medical Deductible	Embedded	Embedded	Embedded	Embedded
Plan Benefits				
INN Deductible (Ind / Fam)	$3,250/$6,500	$3,250/$6,500	$3,250/$6,500	$4,000/$8,000
OON Deductible (Ind / Fam)	-	-	-	-
INN Coinsurance	25%	50%	50%	30%
OON Coinsurance	-	-	-	-
INN Out of Pocket Max (Ind / Fam)	$8,000/$16,000	$9,450/$18,900	$9,450/$18,900	$8,000/$16,000
OON Out of Pocket Max (Ind / Fam)	-	-	-	-
Preferred Virtual PCP: TeleHealth & Medical Chat via KHealth/LHO	Ded, then $0	$0	$0	Ded, then $0
Primary Care Visit	Ded, then $20 Copay	$40	$40	Ded, then $20 Copay
Specialist Visit	Ded, then $50 Copay	$80	$80	Ded, then $50 Copay
Emergency Room	Ded, then $500 Copay	Ded, then 50%	Ded, then 50%	Ded, then $500 Copay
Urgent Care	Ded, then $100 Copay	$80	$80	Ded, then $100 Copay
Inpatient Facility	Ded, then $1,500 Copay	Ded, then 50%	Ded, then 50%	Ded, then $1,500 Copay
Ambulatory Surgical Center/Outpatient Facility Surgery	Ded, then $300 Copay/Ded, then $500 Copay	Ded, then $300 Copay/Ded, then 50%	Ded, then $300 Copay/Ded, then 50%	Ded, then $300 Copay/Ded, then $500 Copay
Preferred Lab / Preferred Office Lab	Ded, then $0	$0	$0	Ded, then $0
INN Lab (Office; Outpatient Hospital)	Ded, then $25 Copay/Ded, then $25 Copay	$20/$25	$20/$25	Ded, then $25 Copay/Ded, then $25 Copay
INN X-Ray (Office; Outpatient Hospital)	Ded, then $50 Copay/Ded, then $150 Copay	Ded, then $75 Copay/Ded, then 50%	Ded, then $75 Copay/Ded, then 50%	Ded, then $50 Copay/Ded, then $150 Copay
INN Adv Diagnostic Imaging (Office; Outpatient Hospital)	Ded, then $150 Copay/Ded, then $250 Copay	Ded, then $150 Copay/Ded, then 50%	Ded, then $150 Copay/Ded, then 50%	Ded, then $150 Copay/Ded, then $250 Copay
Rx Deductible	Med Ded	Tiers 2 & 3, $200/$400	Tiers 2 & 3, $200/$400	Med Ded
Rx Copay (Tier 1 / 2 / 3)	$10/$50/$90	$25/$75/$90	$25/$75/$90	$10/$50/$90

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2) Healthy New York Plans use the Blue Access network and require PCP selection within Anthem's NY service area.

3) Anthem's participating Freestanding Labs are Laboratory Corporation of America or Quest Diagnostics.

4) Medical Text Chat is only available through KHealth, a third-party digital healthcare company

5) Creditable Coverage Results are preliminary, official results provided by the MCC Health Connector Board

Q1 2024 New York Small Group Plans | Albany
Region 1: Albany, Fulton, Montgomery, Rensselaer, Saratoga, Schenectady, Schoharie, Warren and Washington counties

Plan Name	Anthem Silver Blue Access EPO 20/50 4000 30% w/HSA	Anthem Silver Blue Access EPO 30/75 4550 50%	Anthem Bronze EPO 20/50 6100 50% w/HSA	Anthem Bronze Blue Access EPO 20/50 6100 50% w/HSA
Contract Code	9Y7Q	9B6E	9B6Q	9FRR
Premium				
Individual	$754.75	$760.30	$751.11	$689.09
Individual + Spouse	$1,509.50	$1,520.60	$1,502.22	$1,378.18
Individual + Child(ren)	$1,283.08	$1,292.51	$1,276.89	$1,171.45
Family	$2,151.04	$2,166.86	$2,140.66	$1,963.91

Plan Name	Anthem Silver Blue Access EPO 20/50 4000 30% w/HSA WH	Anthem Silver Blue Access EPO 30/75 4550 50% WH	Anthem Bronze EPO 20/50 6100 50% w/HSA WH	Anthem Bronze Blue Access EPO 20/50 6100 50% w/HSA WH
Contract Code	9Y7R	9B69	9FSL	9FSN
Enhanced Embedded Dental and Vision Premium				
Individual	$772.83	$778.48	$770.82	$707.37
Individual + Spouse	$1,545.66	$1,556.96	$1,541.64	$1,414.74
Individual + Child(ren)	$1,313.81	$1,323.42	$1,310.39	$1,202.53
Family	$2,202.57	$2,218.67	$2,196.84	$2,016.00
Plan Details				
Network	Blue Access	Blue Access	PPO/EPO	Blue Access
National Access via Bluecard Program	Full Access	Full Access	Full Access	Full Access
Gatekeeper	No	No	No	No
Rx Network	Base with R90	Base with R90	Base with R90	Base with R90
Formulary	Traditional Open	Traditional Open	Traditional Open	Traditional Open
Creditability Coverage Status	Pass	Pass	Fail	Fail
Embedded / Non-Embedded Medical Deductible	Embedded	Embedded	Embedded	Embedded
Plan Benefits				
INN Deductible (Ind / Fam)	$4,000/$8,000	$4,550/$9,100	$6,100/$12,200	$6,100/$12,200
OON Deductible (Ind / Fam)	-	-	-	-
INN Coinsurance	30%	50%	50%	50%
OON Coinsurance	-	-	-	-
INN Out of Pocket Max (Ind / Fam)	$8,000/$16,000	$9,450/$18,900	$8,000/$16,000	$8,000/$16,000
OON Out of Pocket Max (Ind / Fam)	-	-	-	-
Preferred Virtual PCP: TeleHealth & Medical Chat via KHealth/LHO	Ded, then $0	$0	Ded, then $0	Ded, then $0
Primary Care Visit	Ded, then $20 Copay	$30	Ded, then $20 Copay	Ded, then $20 Copay
Specialist Visit	Ded, then $50 Copay	$75	Ded, then $50 Copay	Ded, then $50 Copay
Emergency Room	Ded, then $500 Copay	Ded, then 50%	Ded, then $500 Copay	Ded, then $500 Copay
Urgent Care	Ded, then $100 Copay	$75	Ded, then $100 Copay	Ded, then $100 Copay
Inpatient Facility	Ded, then $1,500 Copay	Ded, then 50%	Ded, then $1,000 Copay	Ded, then $1,000 Copay
Ambulatory Surgical Center/Outpatient Facility Surgery	Ded, then $300 Copay/Ded, then $500 Copay	Ded, then $300 Copay/Ded, then 50%	Ded, then $300 Copay/Ded, then $500 Copay	Ded, then $300 Copay/Ded, then $500 Copay
Preferred Lab / Preferred Office Lab	Ded, then $0	$0	Ded, then $0	Ded, then $0
INN Lab (Office; Outpatient Hospital)	Ded, then $25 Copay/Ded, then $25 Copay	$20/$25	Ded, then $25 Copay/Ded, then $25 Copay	Ded, then $25 Copay/Ded, then $25 Copay
INN X-Ray (Office; Outpatient Hospital)	Ded, then $50 Copay/Ded, then $150 Copay	Ded, then $75 Copay/Ded, then 50%	Ded, then $50 Copay/Ded, then $150 Copay	Ded, then $50 Copay/Ded, then $150 Copay
INN Adv Diagnostic Imaging (Office; Outpatient Hospital)	Ded, then $150 Copay/Ded, then $250 Copay	Ded, then $150 Copay/Ded, then 50%	Ded, then $150 Copay/Ded, then $250 Copay	Ded, then $150 Copay/Ded, then $250 Copay
Rx Deductible	Med Ded	Tiers 2 & 3, $200/$400	Med Ded	Med Ded
Rx Copay (Tier 1 / 2 / 3)	$10/$50/$90	$25/$75/$90	50%/50%/50%	50%/50%/50%

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Q1 2024 New York Small Group Plans | Albany
Region 1: Albany, Fulton, Montgomery, Rensselaer, Saratoga, Schenectady, Schoharie, Warren and Washington counties

Plan Name	Anthem Bronze Blue Access EPO 20/50 7000 50% w/HSA	Anthem Bronze Blue Access EPO 20/50 8450 50%
Contract Code	9FSS	9B6U
Premium		
Individual	$683.44	$660.67
Individual + Spouse	$1,366.88	$1,321.34
Individual + Child(ren)	$1,161.85	$1,123.14
Family	$1,947.80	$1,882.91

Plan Name	Anthem Bronze Blue Access EPO 20/50 7000 50% w/HSA WH	Anthem Bronze Blue Access EPO 20/50 8450 50% WH
Contract Code	9FSR	9B6R
Enhanced Embedded Dental and Vision Premium		
Individual	$701.63	$679.04
Individual + Spouse	$1,403.26	$1,358.08
Individual + Child(ren)	$1,192.77	$1,154.37
Family	$1,999.65	$1,935.26
Plan Details		
Network	Blue Access	Blue Access
National Access via Bluecard Program	Full Access	Full Access
Gatekeeper	No	No
Rx Network	Base with R90	Base with R90
Formulary	Traditional Open	Traditional Open
Creditability Coverage Status	Fail	Fail
Embedded / Non-Embedded Medical Deductible	Embedded	Embedded
Plan Benefits		
INN Deductible (Ind / Fam)	$7,000/$14,000	$8,450/$16,900
OON Deductible (Ind / Fam)	-	-
INN Coinsurance	50%	50%
OON Coinsurance	-	-
INN Out of Pocket Max (Ind / Fam)	$8,000/$16,000	$9,100/$18,200
OON Out of Pocket Max (Ind / Fam)	-	-
Preferred Virtual PCP: TeleHealth & Medical Chat via KHealth/LHO	Ded, then $0	Ded, then $0
Primary Care Visit	Ded, then $20 Copay	Ded, then $20 Copay
Specialist Visit	Ded, then $50 Copay	Ded, then $50 Copay
Emergency Room	Ded, then $300 Copay	Ded, then $300 Copay
Urgent Care	Ded, then $100 Copay	Ded, then $100 Copay
Inpatient Facility	Ded, then $500 Copay	Ded, then $500 Copay
Ambulatory Surgical Center/Outpatient Facility Surgery	Ded, then $300 Copay/Ded, then $500 Copay	Ded, then $300 Copay/Ded, then $500 Copay
Preferred Lab / Preferred Office Lab	Ded, then $0	Ded, then $0
INN Lab (Office; Outpatient Hospital)	Ded, then $25 Copay/Ded, then $25 Copay	Ded, then $25 Copay/Ded, then $25 Copay
INN X-Ray (Office; Outpatient Hospital)	Ded, then $50 Copay/Ded, then $150 Copay	Ded, then $50 Copay/Ded, then $150 Copay
INN Adv Diagnostic Imaging (Office; Outpatient Hospital)	Ded, then $150 Copay/Ded, then $250 Copay	Ded, then $150 Copay/Ded, then $250 Copay
Rx Deductible	Med Ded	Med Ded
Rx Copay (Tier 1 / 2 / 3)	50%/50%/50%	50%/50%/50%