Medical Plan Offerings– Anthem 2025*

*Carrier availability is based on client headquartered location, as well as client selection

Information shown in this document does not include all plan details or changes. Refer to the Carrier Certificate on TriNet (login.TriNet.com).

Plan Offerings

Plan Highlights	Anthem BA EPO 2500	Anthem BA EPO 5000	Anthem BA EPO/HDHP 3500	Anthem BA PPO 0-35	Anthem BA PPO 3000	Anthem EPO 1000
Network Name	NY: Blue Access (Employer-Sponsored)Non-NY: National PPO Blue Card PPO	NY: Blue Access (Employer-Sponsored)Non-NY: National PPO Blue Card PPO	NY: Blue Access (Employer-Sponsored)Non-NY: National PPO Blue Card PPO	NY: Blue Access (Employer-Sponsored)Non-NY: National PPO Blue Card PPO	NY: Blue Access (Employer-Sponsored)Non-NY: National PPO Blue Card PPO	NY: EPO/PPO (ER Sponsored Plan) Non-NY: National PPO Blue Card PPO
Deductible						
Single (In-Network/OON)	$2,500 / Not covered	$5,000 / Not covered	$3,500 / Not covered	$0 / $3,000	$3,000 / $6,000	$1,000 / Not covered
Family (In-Network/OON)	$6,250 / Not covered	$12,500 / Not covered	$7,000 / Not covered	$0 / $7,500	$7,500 / $15,000	$2,500 / Not covered
Out-of-Pocket Max						
Single (In-Network/OON)	$6,000 / Not covered	$6,000 / Not covered	$7,000 / Not covered	$6,350 / $10,500	$5,080 / $18,500	$4,000 / Not covered
Family (In-Network/OON)	$15,000 / Not covered	$15,000 / Not covered	$14,000 / Not covered	$15,875 / $26,250	$12,700 / $46,250	$10,000 / Not covered
Coinsurance (In-Network/OON)	20% / Not covered	30% / Not covered	10% / Not covered	0% / 30%	20% / 50%	20% / Not covered
Primary / Specialist	$35 / $50	$50 / $75	10% after ded / 10% after ded	$35 / $50	$40 / $70	$20 / $40
Lab & X-Ray	$50	$75	10% after ded	$0	$70	$20
Urgent Care Visit	$75	$75	10% after ded	$75	$75	$75
Emergency Room Visit	$300	$400	10% after ded	$400	$400	$200
Hospital Outpatient (Facility / Surgery)	$50 / 20% after ded	$75 / 30% after ded	10% after ded / 10% after ded	$50 / $100	$70 / 20% after ded	$40 / 20% after ded
Hospital Inpatient	20% after ded	30% after ded	10% after ded	$750	20% after ded	20% after ded
Rx Deductible (Non-Generic)	$100/$200	$100/$200	Integrated w/Med	N/A	$100/$200	$100/$200
Prescriptions (Tier 1 / 2 / 3)	$10 / $35 after Rx ded / $70 after Rx ded	$10 / $35 after Rx ded / $70 after Rx ded	$10 after ded / $35 after ded / $70 after ded	$10 / $50 / $80	$10 / $50 / $80	$10 / $35 after Rx ded / $70 after Rx ded

Plan Offerings

Plan Highlights	Anthem EPO 20	Anthem EPO 4000	Anthem EPO 45	Anthem EPO/HDHP 6400	Anthem HDHP 3500	Anthem HDHP 6400
Network Name	NY: EPO/PPO (ER Sponsored Plan) Non-NY: National PPO Blue Card PPO	NY: EPO/PPO (ER Sponsored Plan) Non-NY: National PPO Blue Card PPO	NY: EPO/PPO (ER Sponsored Plan) Non-NY: National PPO Blue Card PPO	NY: EPO/PPO (ER Sponsored Plan) Non-NY: National PPO Blue Card PPO	NY: EPO/PPO (ER Sponsored Plan) Non-NY: National PPO Blue Card PPO	NY: EPO/PPO (ER Sponsored Plan) Non-NY: National PPO Blue Card PPO
Deductible						
Single (In-Network/OON)	$0 / Not covered	$4,000 / Not covered	$0 / Not covered	$6,400 / Not covered	$3,500 / $7,000	$6,400 / $12,800
Family (In-Network/OON)	$0 / Not covered	$8,000 / Not covered	$0 / Not covered	$12,800 / Not covered	$7,000 / $14,000	$12,800 / $25,600
Out-of-Pocket Max						
Single (In-Network/OON)	$3,500 / Not covered	$6,400 / Not covered	$4,500 / Not covered	$6,400 / Not covered	$7,000 / $13,000	$6,750 / $13,500
Family (In-Network/OON)	$8,750 / Not covered	$12,800 / Not covered	$11,250 / Not covered	$12,800 / Not covered	$14,000 / $26,000	$13,500 / $27,000
Coinsurance (In-Network/OON)	0% / Not covered	20% / Not covered	0% / Not covered	0% / Not covered	10% / 30%	20% / 40%
Primary / Specialist	$20 / $40	$40 / $75	$45 / $65	0% after ded / 0% after ded	10% after ded / 10% after ded	20% after ded / 20% after ded
Lab & X-Ray	$0	$75	$0	0% after ded	10% after ded	20% after ded
Urgent Care Visit	$75	$75	$100	0% after ded	10% after ded	20% after ded
Emergency Room Visit	$200	$200	$300	0% after ded	10% after ded	20% after ded
Hospital Outpatient (Facility / Surgery)	$40 / $100	$75 / 20% after ded	$65 / $250	0% after ded / 0% after ded	10% after ded / 10% after ded	20% after ded / 20% after ded
Hospital Inpatient	$750	20% after ded	$500/day; days 1-5	0% after ded	10% after ded	20% after ded
Rx Deductible (Non-Generic)	$100/$200	$100/$200	$100/$200	Integrated w/Med	Integrated w/Med	Integrated w/Med
Prescriptions (Tier 1 / 2 / 3)	$10 after Rx ded / $35 after Rx ded / $70 after Rx ded	$10 / $35 after Rx ded / $70 after Rx ded	$10 after Rx ded / $35 after Rx ded / $70 after Rx ded	0% after ded / 0% after ded / 0% after ded	$10 after ded / $35 after ded / $70 after ded	$10 after ded / $35 after ded / $70 after ded

Plan Offerings

Plan Highlights	Anthem PPO 0-10	Anthem PPO 0-30	Anthem PPO 1000	Anthem PPO 2000	Anthem PPO 500
Network Name	NY: EPO/PPO (ER Sponsored Plan) Non-NY: National PPO Blue Card PPO	NY: EPO/PPO (ER Sponsored Plan) Non-NY: National PPO Blue Card PPO	NY: EPO/PPO (ER Sponsored Plan) Non-NY: National PPO Blue Card PPO	NY: EPO/PPO (ER Sponsored Plan) Non-NY: National PPO Blue Card PPO	NY: EPO/PPO (ER Sponsored Plan) Non-NY: National PPO Blue Card PPO
Deductible					
Single (In-Network/OON)	$0 / $2,500	$0 / $3,000	$1,000 / $2,000	$2,000 / $4,000	$500 / $1,000
Family (In-Network/OON)	$0 / $6,250	$0 / $7,500	$2,000 / $4,000	$4,000 / $8,000	$1,250 / $2,500
Out-of-Pocket Max					
Single (In-Network/OON)	$2,500 / $5,000	$4,500 / $6,000	$6,000 / $12,000	$6,000 / $12,000	$5,000 / $10,000
Family (In-Network/OON)	$6,250 / $12,500	$11,250 / $15,000	$12,000 / $24,000	$12,000 / $24,000	$12,500 / $25,000
Coinsurance (In-Network/OON)	0% / 30%	0% / 30%	20% / 30%	20% / 40%	10% / 30%
Primary / Specialist	$10 / $20	$30 / $50	$20 / $40	$30 / $60	$20 / $40
Lab & X-Ray	$0	$0	$40	$60	$40
Urgent Care Visit	$75	$75	$75	$75	$75
Emergency Room Visit	$150	$400	$200	$200	$200
Hospital Outpatient (Facility / Surgery)	$20 / $100	$50 / $75	$40 / 20% after ded	$60 / 20% after ded	$40 / 10% after ded
Hospital Inpatient	$250/day; days 1-3	$500/day; days 1-3	20% after ded	20% after ded	10% after ded
Rx Deductible (Non-Generic)	N/A	N/A	N/A	N/A	N/A
Prescriptions (Tier 1 / 2 / 3)	$10 / $35 / $70	$10 / $50 / $80	$10 / $35 / $70	$10 / $35 / $70	$10 / $35 / $70