Medical Plan Offerings– Anthem 2026*

*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 1000	Anthem BA EPO 2500	Anthem BA EPO 5000	Anthem BA EPO/HDHP 2000	Anthem BA EPO/HDHP 4000	Anthem BA PPO 0-35
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: Blue Access (Employer-Sponsored)Non-NY: National PPO Blue Card PPO
Deductible						
Single (In-Network/OON)	$1,000 / Not Covered	$2,500 / Not Covered	$5,000 / Not Covered	$2,000 / Not Covered	$4,000 / Not Covered	$0 / $3,000
Family (In-Network/OON)	$2,500 / Not Covered	$6,250 / Not Covered	$12,500 / Not Covered	$4,000 / Not Covered	$8,000 / Not Covered	$0 / $7,500
Out-of-Pocket Max						
Single (In-Network/OON)	$4,000 / Not Covered	$6,000 / Not Covered	$6,000 / Not Covered	$4,000 / Not Covered	$6,850 / Not Covered	$6,350 / $10,500
Family (In-Network/OON)	$10,000 / Not Covered	$15,000 / Not Covered	$15,000 / Not Covered	$7,500 / Not Covered	$13,700 / Not Covered	$15,875 / $26,250
Coinsurance (In-Network/OON)	20% / Not Covered	20% / Not Covered	30% / Not Covered	10% / 100%	10% / Not Covered	0% / 30%
Primary / Specialist	$20 / $40	$35 / $50	$50 / $75	10% after ded / 10% after ded	10% after ded / 10% after ded	$35 / $50
Lab & X-Ray	$20	$50	$75	10% after ded	10% after ded	$0
Urgent Care Visit	$75	$75	$75	10% after ded	10% after ded	$75
Emergency Room Visit	$200	$300	$400	10% after ded	10% after ded	$400
Hospital Outpatient (Facility / Surgery)	$40 / 20% after ded	$50 / 20% after ded	$75 / 30% after ded	10% after ded / 10% after ded	10% after ded / 10% after ded	$50 / $100
Hospital Inpatient	20% after ded	20% after ded	30% after ded	10% after ded	10% after ded	$750
Rx Deductible (Non-Generic)	$100/$200	$100/$200	$100/$200	Integrated w/ Med	Integrated w/Med	N/A
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 / $35 after Rx ded / $70 after Rx ded	$10 after ded / $35 after ded / $70 after ded	$10 after ded / $35 after ded / $70 after ded	$10 / $50 / $80

Plan Offerings

Plan Highlights	Anthem EPO 1000	Anthem EPO 20	Anthem EPO 4000	Anthem EPO 45	Anthem EPO/HDHP 6400	Anthem HDHP 4000
Network Name	NY: EPO/PPO (Employer-Sponsored Plan)Non-NY: National PPO Blue Card PPO	NY: EPO/PPO (Employer Sponsored Plan)Non-NY: National PPO Blue Card PPO	NY: EPO/PPO (Employer-Sponsored Plan)Non-NY: National PPO Blue Card PPO	NY: EPO/PPO (Employer-Sponsored Plan)Non-NY: National PPO Blue Card PPO	NY: EPO/PPO (Employer-Sponsored Plan)Non-NY: National PPO Blue Card PPO	NY: EPO/PPO (Employer-Sponsored Plan)Non-NY: National PPO Blue Card PPO
Deductible						
Single (In-Network/OON)	$1,000 / Not Covered	$0 / Not Covered	$4,000 / Not Covered	$0 / Not Covered	$6,400 / Not Covered	$4,000 / $8,000
Family (In-Network/OON)	$2,500 / Not Covered	$0 / Not Covered	$8,000 / Not Covered	$0 / Not Covered	$12,800 / Not Covered	$8,000 / $16,000
Out-of-Pocket Max						
Single (In-Network/OON)	$4,000 / Not Covered	$3,500 / Not Covered	$6,400 / Not Covered	$4,500 / Not Covered	$6,400 / Not Covered	$6,850 / $14,000
Family (In-Network/OON)	$10,000 / Not Covered	$8,750 / Not Covered	$12,800 / Not Covered	$11,250 / Not Covered	$12,800 / Not Covered	$13,700 / $28,000
Coinsurance (In-Network/OON)	20% / Not Covered	0% / Not Covered	20% / Not Covered	0% / Not Covered	0% / Not Covered	10% / 50%
Primary / Specialist	$20 / $40	$20 / $40	$40 / $75	$45 / $65	0% after ded / 0% after ded	10% after ded / 10% after ded
Lab & X-Ray	$20	$0	$75	$0	0% after ded	10% after ded
Urgent Care Visit	$75	$75	$75	$100	0% after ded	10% after ded
Emergency Room Visit	$200	$200	$200	$300	0% after ded	10% after ded
Hospital Outpatient (Facility / Surgery)	$40 / 20% after ded	$40 / $100	$75 / 20% after ded	$65 / $250	0% after ded / 0% after ded	10% after ded / 10% after ded
Hospital Inpatient	20% after ded	$750	20% after ded	$500/day; days 1-5	0% after ded	10% after ded
Rx Deductible (Non-Generic)	$100/$200	$100/$200	$100/$200	$100/$200	Integrated w/Med	Integrated w/Med
Prescriptions (Tier 1 / 2 / 3)	$10 / $35 after Rx ded / $70 after Rx ded	$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

Plan Offerings

Plan Highlights	Anthem HDHP 6400	Anthem PPO 0-10	Anthem PPO 1000	Anthem PPO 2000	Anthem PPO 500
Network Name	NY: EPO/PPO (Employer-Sponsored Plan)Non-NY: National PPO Blue Card PPO	NY: EPO/PPO (Employer-Sponsored Plan)Non-NY: National PPO Blue Card PPO	NY: EPO/PPO (Employer-Sponsored Plan)Non-NY: National PPO Blue Card PPO	NY: EPO/PPO (Employer-Sponsored Plan)Non-NY: National PPO Blue Card PPO	NY: EPO/PPO (Employer-Sponsored Plan)Non-NY: National PPO Blue Card PPO
Deductible					
Single (In-Network/OON)	$6,400 / $12,800	$0 / $2,500	$1,000 / $2,000	$2,000 / $4,000	$500 / $1,000
Family (In-Network/OON)	$12,800 / $25,600	$0 / $6,250	$2,000 / $4,000	$4,000 / $8,000	$1,250 / $2,500
Out-of-Pocket Max					
Single (In-Network/OON)	$6,750 / $13,500	$2,500 / $5,000	$6,000 / $12,000	$6,000 / $12,000	$5,000 / $10,000
Family (In-Network/OON)	$13,500 / $27,000	$6,250 / $12,500	$12,000 / $24,000	$12,000 / $24,000	$12,500 / $25,000
Coinsurance (In-Network/OON)	20% / 40%	0% / 30%	20% / 30%	20% / 40%	10% / 30%
Primary / Specialist	20% after ded / 20% after ded	$10 / $20	$20 / $40	$30 / $60	$20 / $40
Lab & X-Ray	20% after ded	$0	$40	$60	$40
Urgent Care Visit	20% after ded	$75	$75	$75	$75
Emergency Room Visit	20% after ded	$150	$200	$200	$200
Hospital Outpatient (Facility / Surgery)	20% after ded / 20% after ded	$20 / $100	$40 / 20% after ded	$60 / 20% after ded	$40 / 10% after ded
Hospital Inpatient	20% after ded	$250/day; days 1-3	20% after ded	20% after ded	10% after ded
Rx Deductible (Non-Generic)	Integrated w/Med	N/A	N/A	N/A	N/A
Prescriptions (Tier 1 / 2 / 3)	$10 after ded / $35 after ded / $70 after ded	$10 / $35 / $70	$10 / $35 / $70	$10 / $35 / $70	$10 / $35 / $70