Q1 2026 New York Small Group Plans | Albany

Region 1: Albany, Fulton, Montgomery, Rensselaer, Saratoga, Schenectady, Schoharie, Warren and Washington Counties

Plan Name	Anthem Platinum EPO 5/25 0%	Anthem Platinum Blue Access EPO 5/25 0%	Anthem Platinum EPO 20/40 0%
Contract Code	93BH	93AL	8TYN
Premium			
Individual	$1,459.94	$1,338.96	$1,445.48
Individual + Spouse	$2,919.88	$2,677.92	$2,890.96
Individual + Child(ren)	$2,481.90	$2,276.23	$2,457.32
Family	$4,160.83	$3,816.04	$4,119.62

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
Contract Code	93AQ	93AM	93CX
Enhanced Embedded Dental and Vision Premium			
Individual	$1,479.26	$1,357.12	$1,464.80
Individual + Spouse	$2,958.52	$2,714.24	$2,929.60
Individual + Child(ren)	$2,514.74	$2,307.10	$2,490.16
Family	$4,215.89	$3,867.79	$4,174.68
Plan Details			
Network	PPO/EPO	Blue Access	PPO/EPO
National Access via Bluecard Program	Yes	Yes	Yes
Gatekeeper	No	No	No
Rx Network	Base Rx	Base Rx	Base Rx
Formulary	Traditional Open	Select	Traditional Open
MA Creditability Coverage Status	Yes	Yes	Yes
Embedded / Non-Embedded Medical Deductible	Embedded	Embedded	Embedded
Medicare Part D Creditable Coverage Status	Yes	Yes	Yes
Plan Benefits			
Deductible (Ind / Fam)	$0 / $0	$0 / $0	$0 / $0
Coinsurance	0%	0%	0%
Out of Pocket Max (Ind / Fam)	$3,900 / $7,800	$3,900 / $7,800	$3,500 / $7,000
PCP / Preferred PCP	$5	$5	$20
Virtual Telehealth (LiveHealth Online)	No Charge	No Charge	No Charge
Specialist / Preferred Specialist	$25	$25	$40
Emergency Room	$300	$300	$300
Urgent Care	$50	$50	$50
Inpatient Facility	$400	$400	$500
Ambulatory Surgical Center / Outpatient Facility Surgery	$50 / $300	$50 / $300	$100 / $500
Preferred Lab	No Charge	No Charge	No Charge
Lab (Office / Outpatient Hospital)	No Charge	No Charge	No Charge
X-Ray (Office / Outpatient Hospital)	$50 / $150	$50 / $150	$50 / $150
Adv Diagnostic Imaging (Office / Outpatient Hospital)	$150 / $250	$150 / $250	$150 / $250
Rx Deductible (Tiers 2 & 3 only, unless specified)	$100 (IND) / $200 (FAM)	$100 (IND) / $200 (FAM)	$100 (IND) / $200 (FAM)
Rx Copay (Tier 1 / 2 / 3)	$10 / $35 / $70	$10 / $35 / $70	$10 / $35 / $70

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Q1 2026 New York Small Group Plans | Albany

Region 1: Albany, Fulton, Montgomery, Rensselaer, Saratoga, Schenectady, Schoharie, Warren and Washington Counties

Plan Name	Anthem Platinum Blue Access EPO 20/40 0%	Anthem Platinum EPO 15/35 300 10%	Anthem Platinum Blue Access EPO 15/35 300 10%
Contract Code	93DD	93BR	93C9
Premium			
Individual	$1,325.89	$1,419.81	$1,302.42
Individual + Spouse	$2,651.78	$2,839.62	$2,604.84
Individual + Child(ren)	$2,254.01	$2,413.68	$2,214.11
Family	$3,778.79	$4,046.46	$3,711.90

Plan Name	Anthem Platinum Blue Access EPO 20/40 0% WH	Anthem Platinum EPO 15/35 300 10% WH	Anthem Platinum Blue Access EPO 15/35 300 10% WH
Contract Code	8TYT	93C8	93CH
Enhanced Embedded Dental and Vision Premium			
Individual	$1,344.05	$1,441.44	$1,322.77
Individual + Spouse	$2,688.10	$2,882.88	$2,645.54
Individual + Child(ren)	$2,284.89	$2,450.45	$2,248.71
Family	$3,830.54	$4,108.10	$3,769.89
Plan Details			
Network	Blue Access	PPO/EPO	Blue Access
National Access via Bluecard Program	Yes	Yes	Yes
Gatekeeper	No	No	No
Rx Network	Base Rx	Base Rx	Base Rx
Formulary	Select	Traditional Open	Select
MA Creditability Coverage Status	Yes	Yes	Yes
Embedded / Non-Embedded Medical Deductible	Embedded	Embedded	Embedded
Medicare Part D Creditable Coverage Status	Yes	Yes	Yes
Plan Benefits			
Deductible (Ind / Fam)	$0 / $0	$300 / $600	$300 / $600
Coinsurance	0%	10%	10%
Out of Pocket Max (Ind / Fam)	$3,500 / $7,000	$3,200 / $6,400	$3,200 / $6,400
PCP / Preferred PCP	$20	$15	$15
Virtual Telehealth (LiveHealth Online)	No Charge	No Charge	No Charge
Specialist / Preferred Specialist	$40	$35	$35
Emergency Room	$300	Ded, then 10%	Ded, then 10%
Urgent Care	$50	$50	$50
Inpatient Facility	$500	Ded, then 10%	Ded, then 10%
Ambulatory Surgical Center / Outpatient Facility Surgery	$100 / $500	Ded, then $50 Copay / Ded, then 10%	Ded, then $50 Copay / Ded, then 10%
Preferred Lab	No Charge	No Charge	No Charge
Lab (Office / Outpatient Hospital)	No Charge	$20 / $25	$20 / $25
X-Ray (Office / Outpatient Hospital)	$50 / $150	$75 / Ded, then 10%	$75 / Ded, then 10%
Adv Diagnostic Imaging (Office / Outpatient Hospital)	$150 / $250	$150 / Ded, then 10%	$150 / Ded, then 10%
Rx Deductible (Tiers 2 & 3 only, unless specified)	$100 (IND) / $200 (FAM)	$200 (IND) / $400 (FAM)	$200 (IND) / $400 (FAM)
Rx Copay (Tier 1 / 2 / 3)	$10 / $35 / $70	$10 / $50 / $90	$10 / $50 / $90

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Q1 2026 New York Small Group Plans | Albany

Region 1: Albany, Fulton, Montgomery, Rensselaer, Saratoga, Schenectady, Schoharie, Warren and Washington Counties

Plan Name	Anthem Guided Advantage Platinum Blue Access EPO 5/25/30/60 500 10%	Anthem Gold EPO 30/60 0%	Anthem Gold Blue Access EPO 30/60 0%
Contract Code	93CG	93A6	93BA
Premium			
Individual	$1,286.80	$1,307.04	$1,200.06
Individual + Spouse	$2,573.60	$2,614.08	$2,400.12
Individual + Child(ren)	$2,187.56	$2,221.97	$2,040.10
Family	$3,667.38	$3,725.06	$3,420.17

Plan Name	Anthem Guided Advantage Platinum Blue Access EPO 5/25/30/60 500 10% WH	Anthem Gold EPO 30/60 0% WH	Anthem Gold Blue Access EPO 30/60 0% WH
Contract Code	93A8	93AN	93D6
Enhanced Embedded Dental and Vision Premium			
Individual	$1,307.04	$1,326.24	$1,218.22
Individual + Spouse	$2,614.08	$2,652.48	$2,436.44
Individual + Child(ren)	$2,221.97	$2,254.61	$2,070.97
Family	$3,725.06	$3,779.78	$3,471.93
Plan Details			
Network	Blue Access	PPO/EPO	Blue Access
National Access via Bluecard Program	Yes	Yes	Yes
Gatekeeper	No	No	No
Rx Network	Base Rx	Base Rx	Base Rx
Formulary	Select	Traditional Open	Select
MA Creditability Coverage Status	Yes	Yes	Yes
Embedded / Non-Embedded Medical Deductible	Embedded	Embedded	Embedded
Medicare Part D Creditable Coverage Status	Yes	Yes	Yes
Plan Benefits			
Deductible (Ind / Fam)	$500 / $1,000	$0 / $0	$0 / $0
Coinsurance	10%	0%	0%
Out of Pocket Max (Ind / Fam)	$3,000 / $6,000	$9,150 / $18,300	$9,150 / $18,300
PCP / Preferred PCP	$25 / $5	$30	$30
Virtual Telehealth (LiveHealth Online)	No Charge	No Charge	No Charge
Specialist / Preferred Specialist	$60 / $30	$60	$60
Emergency Room	Ded, then 30%	$850	$850
Urgent Care	$75	$90	$90
Inpatient Facility	Ded, then 10%	$600	$600
Ambulatory Surgical Center / Outpatient Facility Surgery	Ded, then $150 Copay / Ded, then 10%	$300 / $500	$300 / $500
Preferred Lab	No Charge	No Charge	No Charge
Lab (Office / Outpatient Hospital)	Tiered benefit depends on POS / Ded, then 10%	No Charge	No Charge
X-Ray (Office / Outpatient Hospital)	$50 / Ded, then 10%	$100 / $150	$100 / $150
Adv Diagnostic Imaging (Office / Outpatient Hospital)	$150 / Ded, then 10%	$200 / $250	$200 / $250
Rx Deductible (Tiers 2 & 3 only, unless specified)	Med Ded	$200 (IND) / $400 (FAM)	$200 (IND) / $400 (FAM)
Rx Copay (Tier 1 / 2 / 3)	$5 / 10% / 10%	$10 / $65 / $100	$10 / $65 / $100

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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 2026 New York Small Group Plans | Albany

Region 1: Albany, Fulton, Montgomery, Rensselaer, Saratoga, Schenectady, Schoharie, Warren and Washington Counties

Plan Name	Anthem Gold EPO 50/60 1200 10%	Anthem Gold Blue Access EPO 50/60 1200 10%	Anthem Gold Blue Access EPO 30/65 1600 20%
Contract Code	93C1	93AC	93DF
Premium			
Individual	$1,245.05	$1,143.73	$1,100.59
Individual + Spouse	$2,490.10	$2,287.46	$2,201.18
Individual + Child(ren)	$2,116.59	$1,944.34	$1,871.00
Family	$3,548.39	$3,259.63	$3,136.68

Plan Name	Anthem Gold EPO 50/60 1200 10% WH	Anthem Gold Blue Access EPO 50/60 1200 10% WH	Anthem Gold Blue Access EPO 30/65 1600 20% WH
Contract Code	93BX	93CZ	93AR
Enhanced Embedded Dental and Vision Premium			
Individual	$1,266.79	$1,164.21	$1,120.95
Individual + Spouse	$2,533.58	$2,328.42	$2,241.90
Individual + Child(ren)	$2,153.54	$1,979.16	$1,905.62
Family	$3,610.35	$3,318.00	$3,194.71
Plan Details			
Network	PPO/EPO	Blue Access	Blue Access
National Access via Bluecard Program	Yes	Yes	Yes
Gatekeeper	No	No	No
Rx Network	Base Rx	Base Rx	Base Rx
Formulary	Traditional Open	Select	Select
MA Creditability Coverage Status	Yes	Yes	Yes
Embedded / Non-Embedded Medical Deductible	Embedded	Embedded	Embedded
Medicare Part D Creditable Coverage Status	Yes	Yes	Yes
Plan Benefits			
Deductible (Ind / Fam)	$1,200 / $2,400	$1,200 / $2,400	$1,600 / $3,200
Coinsurance	10%	10%	20%
Out of Pocket Max (Ind / Fam)	$7,000 / $14,000	$7,000 / $14,000	$7,500 / $15,000
PCP / Preferred PCP	$50	$50	$30
Virtual Telehealth (LiveHealth Online)	No Charge	No Charge	No Charge
Specialist / Preferred Specialist	$60	$60	$65
Emergency Room	Ded, then $750 Copay	Ded, then $750 Copay	Ded, then $500 Copay
Urgent Care	$100	$100	$85
Inpatient Facility	Ded, then 10%	Ded, then 10%	Ded, then 20%
Ambulatory Surgical Center / Outpatient Facility Surgery	Ded, then $150 Copay / Ded, then $300 Copay	Ded, then $150 Copay / Ded, then $300 Copay	Ded, then $200 Copay / Ded, then $300 Copay
Preferred Lab	No Charge	No Charge	No Charge
Lab (Office / Outpatient Hospital)	No Charge	No Charge	No Charge
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 $200 Copay
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 $300 Copay
Rx Deductible (Tiers 2 & 3 only, unless specified)	$150 (IND) / $300 (FAM)	$150 (IND) / $300 (FAM)	$200 (IND) / $400 (FAM)
Rx Copay (Tier 1 / 2 / 3)	$10 / $50 / $90	$10 / $50 / $90	$10 / $50 / 50%

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Q1 2026 New York Small Group Plans | Albany

Region 1: Albany, Fulton, Montgomery, Rensselaer, Saratoga, Schenectady, Schoharie, Warren and Washington Counties

Plan Name	Anthem Gold EPO 20/50 1800 15% w/HSA PrevRx	Anthem Gold Blue Access EPO 20/50 1800 15% w/HSA PrevRx	Anthem Gold EPO 15/40 1950 15%
Contract Code	939V	93AF	8TYR
Premium			
Individual	$1,165.94	$1,071.91	$1,217.64
Individual + Spouse	$2,331.88	$2,143.82	$2,435.28
Individual + Child(ren)	$1,982.10	$1,822.25	$2,069.99
Family	$3,322.93	$3,054.94	$3,470.27

Plan Name	Anthem Gold EPO 20/50 1800 15% w/HSA PrevRx WH	Anthem Gold Blue Access EPO 20/50 1800 15% w/HSA PrevRx WH	Anthem Gold EPO 15/40 1950 15% WH
Contract Code	8TYG	93C0	93BP
Enhanced Embedded Dental and Vision Premium			
Individual	$1,187.68	$1,092.38	$1,239.27
Individual + Spouse	$2,375.36	$2,184.76	$2,478.54
Individual + Child(ren)	$2,019.06	$1,857.05	$2,106.76
Family	$3,384.89	$3,113.28	$3,531.92
Plan Details			
Network	PPO/EPO	Blue Access	PPO/EPO
National Access via Bluecard Program	Yes	Yes	Yes
Gatekeeper	No	No	No
Rx Network	Base Rx	Base Rx	Base Rx
Formulary	Traditional Open	Select	Traditional Open
MA Creditability Coverage Status	Yes	Yes	Yes
Embedded / Non-Embedded Medical Deductible	Not Embedded	Not Embedded	Embedded
Medicare Part D Creditable Coverage Status	Yes	Yes	Yes
Plan Benefits			
Deductible (Ind / Fam)	$1,800 / $3,600	$1,800 / $3,600	$1,950 / $3,900
Coinsurance	15%	15%	15%
Out of Pocket Max (Ind / Fam)	$6,100 / $12,200	$6,100 / $12,200	$8,700 / $17,400
PCP / Preferred PCP	Ded, then $20 Copay	Ded, then $20 Copay	$15
Virtual Telehealth (LiveHealth Online)	Ded, then No Charge	Ded, then No Charge	No Charge
Specialist / Preferred Specialist	Ded, then $50 Copay	Ded, then $50 Copay	$40
Emergency Room	Ded, then 15%	Ded, then 15%	Ded, then $750 Copay
Urgent Care	Ded, then $100 Copay	Ded, then $100 Copay	$75
Inpatient Facility	Ded, then 15%	Ded, then 15%	Ded, then 15%
Ambulatory Surgical Center / Outpatient Facility Surgery	Ded, then 15%	Ded, then 15%	Ded, then $150 Copay / Ded, then $300 Copay
Preferred Lab	Ded, then 15%	Ded, then 15%	No Charge
Lab (Office / Outpatient Hospital)	Ded, then 15% / Ded, then 15%	Ded, then 15% / Ded, then 15%	No Charge
X-Ray (Office / Outpatient Hospital)	Ded, then 15% / Ded, then 15%	Ded, then 15% / Ded, then 15%	Ded, then $50 Copay / Ded, then $150 Copay
Adv Diagnostic Imaging (Office / Outpatient Hospital)	Ded, then 15% / Ded, then 15%	Ded, then 15% / Ded, then 15%	Ded, then $150 Copay / Ded, then $250 Copay
Rx Deductible (Tiers 2 & 3 only, unless specified)	Med Ded [Tiers 1-3]	Med Ded [Tiers 1-3]	$200 (IND) / $400 (FAM)
Rx Copay (Tier 1 / 2 / 3)	$10 / 15% / 15%	$10 / 15% / 15%	$10 / $40 / $80

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Q1 2026 New York Small Group Plans | Albany

Region 1: Albany, Fulton, Montgomery, Rensselaer, Saratoga, Schenectady, Schoharie, Warren and Washington Counties

Plan Name	Anthem Gold Blue Access EPO 15/40 1950 15%	Anthem Gold EPO 25/50 1950 30%	Anthem Gold Blue Access EPO 25/50 1950 30%
Contract Code	93CN	93A5	939U
Premium			
Individual	$1,118.87	$1,205.38	$1,107.76
Individual + Spouse	$2,237.74	$2,410.76	$2,215.52
Individual + Child(ren)	$1,902.08	$2,049.15	$1,883.19
Family	$3,188.78	$3,435.33	$3,157.12

Plan Name	Anthem Gold Blue Access EPO 15/40 1950 15% WH	Anthem Gold EPO 25/50 1950 30% WH	Anthem Gold Blue Access EPO 25/50 1950 30% WH
Contract Code	93D8	93CL	93CQ
Enhanced Embedded Dental and Vision Premium			
Individual	$1,139.22	$1,227.12	$1,128.12
Individual + Spouse	$2,278.44	$2,454.24	$2,256.24
Individual + Child(ren)	$1,936.67	$2,086.10	$1,917.80
Family	$3,246.78	$3,497.29	$3,215.14
Plan Details			
Network	Blue Access	PPO/EPO	Blue Access
National Access via Bluecard Program	Yes	Yes	Yes
Gatekeeper	No	No	No
Rx Network	Base Rx	Base Rx	Base Rx
Formulary	Select	Traditional Open	Select
MA Creditability Coverage Status	Yes	Yes	Yes
Embedded / Non-Embedded Medical Deductible	Embedded	Embedded	Embedded
Medicare Part D Creditable Coverage Status	Yes	Yes	Yes
Plan Benefits			
Deductible (Ind / Fam)	$1,950 / $3,900	$1,950 / $3,900	$1,950 / $3,900
Coinsurance	15%	30%	30%
Out of Pocket Max (Ind / Fam)	$8,700 / $17,400	$7,500 / $15,000	$7,500 / $15,000
PCP / Preferred PCP	$15	$25	$25
Virtual Telehealth (LiveHealth Online)	No Charge	No Charge	No Charge
Specialist / Preferred Specialist	$40	$50	$50
Emergency Room	Ded, then $750 Copay	Ded, then $750 Copay	Ded, then $750 Copay
Urgent Care	$75	$80	$80
Inpatient Facility	Ded, then 15%	Ded, then 30%	Ded, then 30%
Ambulatory Surgical Center / Outpatient Facility Surgery	Ded, then $150 Copay / Ded, then $300 Copay	Ded, then $200 Copay / Ded, then $500 Copay	Ded, then $200 Copay / Ded, then $500 Copay
Preferred Lab	No Charge	No Charge	No Charge
Lab (Office / Outpatient Hospital)	No Charge	No Charge	No Charge
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
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
Rx Deductible (Tiers 2 & 3 only, unless specified)	$200 (IND) / $400 (FAM)	$200 (IND) / $400 (FAM)	$200 (IND) / $400 (FAM)
Rx Copay (Tier 1 / 2 / 3)	$10 / $40 / $80	$10 / $50 / $90	$10 / $50 / $90

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1) Anthem Blue Cross and Blue Shield is the trade name of Anthem HealthChoice HMO, Inc. and Anthem HealthChoice Assurance, Inc. Anthem Blue Cross and Blue Shield 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.
2) Healthy New York Plans use the Blue Access network and require PCP selection within Anthem's NY service area.
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Q1 2026 New York Small Group Plans | Albany

Region 1: Albany, Fulton, Montgomery, Rensselaer, Saratoga, Schenectady, Schoharie, Warren and Washington Counties

Plan Name	Anthem Guided Advantage Gold EPO 20/40/50/80 2000 20%	Anthem Guided Advantage Gold Blue Access EPO 20/40/50/80 2000 20%	Anthem Gold Healthy New York Blue Access GEPO 25/40 775 0%
Contract Code	93BK	93A0	93A3
Premium			
Individual	$1,174.50	$1,079.66	$947.35
Individual + Spouse	$2,349.00	$2,159.32	$1,894.70
Individual + Child(ren)	$1,996.65	$1,835.42	$1,610.50
Family	$3,347.33	$3,077.03	$2,699.95

Plan Name	Anthem Guided Advantage Gold EPO 20/40/50/80 2000 20% WH	Anthem Guided Advantage Gold Blue Access EPO 20/40/50/80 2000 20% WH
Contract Code	939W	8TYJ
Enhanced Embedded Dental and Vision Premium		
Individual	$1,196.13	$1,100.13
Individual + Spouse	$2,392.26	$2,200.26
Individual + Child(ren)	$2,033.42	$1,870.22
Family	$3,408.97	$3,135.37

Plan Details			
Network	PPO/EPO	Blue Access	Blue Access
National Access via Bluecard Program	Yes	Yes	Yes
Gatekeeper	No	No	Yes
Rx Network	Base Rx	Base Rx	Base Rx
Formulary	Traditional Open	Select	Select
MA Creditability Coverage Status	Yes	Yes	Yes
Embedded / Non-Embedded Medical Deductible	Embedded	Embedded	Embedded
Medicare Part D Creditable Coverage Status	Yes	Yes	Yes
Plan Benefits			
Deductible (Ind / Fam)	$2,000 / $4,000	$2,000 / $4,000	$775 / $1,550
Coinsurance	20%	20%	0%
Out of Pocket Max (Ind / Fam)	$7,500 / $15,000	$7,500 / $15,000	$10,150 / $20,300
PCP / Preferred PCP	$40 / $20	$40 / $20	Ded, then $25 Copay
Virtual Telehealth (LiveHealth Online)	No Charge	No Charge	Ded, then $25 Copay
Specialist / Preferred Specialist	$80 / $50	$80 / $50	Ded, then $40 Copay
Emergency Room	Ded, then 40%	Ded, then 40%	Ded, then $150 Copay
Urgent Care	$75	$75	Ded, then $60 Copay
Inpatient Facility	Ded, then 20%	Ded, then 20%	Ded, then $1,000 Copay
Ambulatory Surgical Center / Outpatient Facility Surgery	Ded, then $200 Copay / Ded, then 20%	Ded, then $200 Copay / Ded, then 20%	Ded, then $100 Copay
Preferred Lab	No Charge	No Charge	Ded, then $40 Copay
Lab (Office / Outpatient Hospital)	Tiered benefit depends on POS / Ded, then 20%	Tiered benefit depends on POS / Ded, then 20%	Cost-share depends on POS / Ded, then $40 Copay
X-Ray (Office / Outpatient Hospital)	$50 / Ded, then 20%	$50 / Ded, then 20%	Ded, then $40 Copay / Ded, then $40 Copay
Adv Diagnostic Imaging (Office / Outpatient Hospital)	$150 / Ded, then 20%	$150 / Ded, then 20%	Ded, then $40 Copay / Ded, then $40 Copay
Rx Deductible (Tiers 2 & 3 only, unless specified)	Med Ded	Med Ded	N/A [Tiers 1-3]
Rx Copay (Tier 1 / 2 / 3)	$10 / 20% / 30%	$10 / 20% / 30%	$10 / $35 / $70

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Q1 2026 New York Small Group Plans | Albany

Region 1: Albany, Fulton, Montgomery, Rensselaer, Saratoga, Schenectady, Schoharie, Warren and Washington Counties

Plan Name	Anthem Virtual Access Plus Silver Blue Access EPO 60/125 0%	Anthem Silver EPO 45/75 2650 30%	Anthem Silver Blue Access EPO 45/75 2650 30%
Contract Code	93C2	8TYV	939Y
Premium			
Individual	$1,065.43	$1,069.60	$984.59
Individual + Spouse	$2,130.86	$2,139.20	$1,969.18
Individual + Child(ren)	$1,811.23	$1,818.32	$1,673.80
Family	$3,036.48	$3,048.36	$2,806.08

Plan Name	Anthem Virtual Access Plus Silver Blue Access EPO 60/125 0% WH	Anthem Silver EPO 45/75 2650 30% WH	Anthem Silver Blue Access EPO 45/75 2650 30% WH
Contract Code	93AS	8TYS	93BW
Enhanced Embedded Dental and Vision Premium			
Individual	$1,083.59	$1,091.46	$1,005.06
Individual + Spouse	$2,167.18	$2,182.92	$2,010.12
Individual + Child(ren)	$1,842.10	$1,855.48	$1,708.60
Family	$3,088.23	$3,110.66	$2,864.42
Plan Details			
Network	Blue Access	PPO/EPO	Blue Access
National Access via Bluecard Program	Yes	Yes	Yes
Gatekeeper	No	No	No
Rx Network	Base Rx	Base Rx	Base Rx
Formulary	Select	Traditional Open	Select
MA Creditability Coverage Status	Yes	Yes	Yes
Embedded / Non-Embedded Medical Deductible	Embedded	Embedded	Embedded
Medicare Part D Creditable Coverage Status	Yes	Yes	Yes
Plan Benefits			
Deductible (Ind / Fam)	$0 / $0	$2,650 / $5,300	$2,650 / $5,300
Coinsurance	0%	30%	30%
Out of Pocket Max (Ind / Fam)	$10,150 / $20,300	$9,950 / $19,900	$9,950 / $19,900
PCP / Preferred PCP	$60	$45	$45
Virtual Telehealth (LiveHealth Online)	No Charge	No Charge	No Charge
Specialist / Preferred Specialist	$125	$75	$75
Emergency Room	$2,800	Ded, then $1,000 Copay	Ded, then $1,000 Copay
Urgent Care	$200	$100	$100
Inpatient Facility	$2,800	Ded, then 30%	Ded, then 30%
Ambulatory Surgical Center / Outpatient Facility Surgery	$500 / $1,000	Ded, then $300 Copay / Ded, then $500 Copay	Ded, then $300 Copay / Ded, then $500 Copay
Preferred Lab	No Charge	No Charge	No Charge
Lab (Office / Outpatient Hospital)	Cost-share depends on POS / $20	No Charge	No Charge
X-Ray (Office / Outpatient Hospital)	$200 / $200	Ded, then $50 Copay / Ded, then $150 Copay	Ded, then $50 Copay / Ded, then $150 Copay
Adv Diagnostic Imaging (Office / Outpatient Hospital)	$250 / $300	Ded, then $150 Copay / Ded, then $250 Copay	Ded, then $150 Copay / Ded, then $250 Copay
Rx Deductible (Tiers 2 & 3 only, unless specified)	$200 (IND) / $400 (FAM)	$300 (IND) / $600 (FAM)	$300 (IND) / $600 (FAM)
Rx Copay (Tier 1 / 2 / 3)	$15 / $75 / $100	$35 / $75 / 50%	$35 / $75 / 50%

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Q1 2026 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 2750 40% w/HSA	Anthem Silver EPO 30/60 3300 30% w/HSA PrevRx	Anthem Silver Blue Access EPO 30/60 3300 30% w/HSA PrevRx
Contract Code	8TYH	93A7	93CT
Premium			
Individual	$921.21	$993.50	$915.43
Individual + Spouse	$1,842.42	$1,987.00	$1,830.86
Individual + Child(ren)	$1,566.06	$1,688.95	$1,556.23
Family	$2,625.45	$2,831.48	$2,608.98

Plan Name	Anthem Silver Blue Access EPO 2750 40% w/HSA WH	Anthem Silver EPO 30/60 3300 30% w/HSA PrevRx WH	Anthem Silver Blue Access EPO 30/60 3300 30% w/HSA PrevRx WH
Contract Code	93D1	93B9	93A9
Enhanced Embedded Dental and Vision Premium			
Individual	$941.68	$1,015.35	$935.90
Individual + Spouse	$1,883.36	$2,030.70	$1,871.80
Individual + Child(ren)	$1,600.86	$1,726.10	$1,591.03
Family	$2,683.79	$2,893.75	$2,667.32
Plan Details			
Network	Blue Access	PPO/EPO	Blue Access
National Access via Bluecard Program	Yes	Yes	Yes
Gatekeeper	No	No	No
Rx Network	Base Rx	Base Rx	Base Rx
Formulary	Select	Traditional Open	Select
MA Creditability Coverage Status	Yes	Yes	Yes
Embedded / Non-Embedded Medical Deductible	Not Embedded	Not Embedded	Not Embedded
Medicare Part D Creditable Coverage Status	Yes	Yes	Yes
Plan Benefits			
Deductible (Ind / Fam)	$2,750 / $5,500	$3,300 / $6,600	$3,300 / $6,600
Coinsurance	40%	30%	30%
Out of Pocket Max (Ind / Fam)	$8,450 / $16,900	$8,450 / $16,900	$8,450 / $16,900
PCP / Preferred PCP	Ded, then 40%	Ded, then $30 Copay	Ded, then $30 Copay
Virtual Telehealth (LiveHealth Online)	Ded, then No Charge	Ded, then No Charge	Ded, then No Charge
Specialist / Preferred Specialist	Ded, then 40%	Ded, then $60 Copay	Ded, then $60 Copay
Emergency Room	Ded, then 50%	Ded, then 30%	Ded, then 30%
Urgent Care	Ded, then 40%	Ded, then $100 Copay	Ded, then $100 Copay
Inpatient Facility	Ded, then 40%	Ded, then 30%	Ded, then 30%
Ambulatory Surgical Center / Outpatient Facility Surgery	Ded, then 40%	Ded, then 30%	Ded, then 30%
Preferred Lab	Ded, then 40%	Ded, then 30%	Ded, then 30%
Lab (Office / Outpatient Hospital)	Ded, then 40% / Ded, then 40%	Ded, then 30% / Ded, then 30%	Ded, then 30% / Ded, then 30%
X-Ray (Office / Outpatient Hospital)	Ded, then 40% / Ded, then 40%	Ded, then 30% / Ded, then 30%	Ded, then 30% / Ded, then 30%
Adv Diagnostic Imaging (Office / Outpatient Hospital)	Ded, then 40% / Ded, then 40%	Ded, then 30% / Ded, then 30%	Ded, then 30% / Ded, then 30%
Rx Deductible (Tiers 2 & 3 only, unless specified)	Med Ded [Tiers 1-3]	Med Ded [Tiers 1-3]	Med Ded [Tiers 1-3]
Rx Copay (Tier 1 / 2 / 3)	$10 / $50 / 50%	$10 / 30% / 50%	$10 / 30% / 50%

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Q1 2026 New York Small Group Plans | Albany

Region 1: Albany, Fulton, Montgomery, Rensselaer, Saratoga, Schenectady, Schoharie, Warren and Washington Counties

Plan Name	Anthem Silver EPO 40/80 3450 50%	Anthem Silver Blue Access EPO 40/80 3450 50%	Anthem Silver EPO 40/80 4000 40%
Contract Code	93DC	93C5	93DB
Premium			
Individual	$1,061.27	$976.84	$1,041.96
Individual + Spouse	$2,122.54	$1,953.68	$2,083.92
Individual + Child(ren)	$1,804.16	$1,660.63	$1,771.33
Family	$3,024.62	$2,783.99	$2,969.59

Plan Name	Anthem Silver EPO 40/80 3450 50% WH	Anthem Silver Blue Access EPO 40/80 3450 50% WH	Anthem Silver EPO 40/80 4000 40% WH
Contract Code	93AV	93B4	93DE
Enhanced Embedded Dental and Vision Premium			
Individual	$1,083.01	$997.43	$1,063.81
Individual + Spouse	$2,166.02	$1,994.86	$2,127.62
Individual + Child(ren)	$1,841.12	$1,695.63	$1,808.48
Family	$3,086.58	$2,842.68	$3,031.86
Plan Details			
Network	PPO/EPO	Blue Access	PPO/EPO
National Access via Bluecard Program	Yes	Yes	Yes
Gatekeeper	No	No	No
Rx Network	Base Rx	Base Rx	Base Rx
Formulary	Traditional Open	Select	Traditional Open
MA Creditability Coverage Status	No	No	No
Embedded / Non-Embedded Medical Deductible	Embedded	Embedded	Embedded
Medicare Part D Creditable Coverage Status	Yes	Yes	Yes
Plan Benefits			
Deductible (Ind / Fam)	$3,450 / $6,900	$3,450 / $6,900	$4,000 / $8,000
Coinsurance	50%	50%	40%
Out of Pocket Max (Ind / Fam)	$9,700 / $19,400	$9,700 / $19,400	$9,800 / $19,600
PCP / Preferred PCP	$40	$40	$40
Virtual Telehealth (LiveHealth Online)	No Charge	No Charge	No Charge
Specialist / Preferred Specialist	$80	$80	$80
Emergency Room	Ded, then 50%	Ded, then 50%	Ded, then 50%
Urgent Care	$100	$100	$125
Inpatient Facility	Ded, then 50%	Ded, then 50%	Ded, then 40%
Ambulatory Surgical Center / Outpatient Facility Surgery	Ded, then $300 Copay / Ded, then 50%	Ded, then $300 Copay / Ded, then 50%	Ded, then $500 Copay / Ded, then 40%
Preferred Lab	No Charge	No Charge	No Charge
Lab (Office / Outpatient Hospital)	$20 / $25	$20 / $25	$20 / $25
X-Ray (Office / Outpatient Hospital)	$75 / Ded, then 50%	$75 / Ded, then 50%	$75 / Ded, then 40%
Adv Diagnostic Imaging (Office / Outpatient Hospital)	$150 / Ded, then 50%	$150 / Ded, then 50%	$150 / Ded, then 40%
Rx Deductible (Tiers 2 & 3 only, unless specified)	$200 (IND) / $400 (FAM)	$200 (IND) / $400 (FAM)	$200 (IND) / $400 (FAM)
Rx Copay (Tier 1 / 2 / 3)	$25 / $75 / $90	$25 / $75 / $90	$15 / $65 / 50%

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Q1 2026 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 40/80 4000 40%	Anthem Silver EPO 20/50 4100 30% w/HSA PrevRx	Anthem Silver Blue Access EPO 20/50 4100 30% w/HSA PrevRx
Contract Code	8TYL	93DG	93AZ
Premium			
Individual	$959.38	$978.69	$902.01
Individual + Spouse	$1,918.76	$1,957.38	$1,804.02
Individual + Child(ren)	$1,630.95	$1,663.77	$1,533.42
Family	$2,734.23	$2,789.27	$2,570.73

Plan Name	Anthem Silver Blue Access EPO 40/80 4000 40% WH	Anthem Silver EPO 20/50 4100 30% w/HSA PrevRx WH	Anthem Silver Blue Access EPO 20/50 4100 30% w/HSA PrevRx WH
Contract Code	93AA	93AX	93CA
Enhanced Embedded Dental and Vision Premium			
Individual	$979.96	$1,000.67	$922.60
Individual + Spouse	$1,959.92	$2,001.34	$1,845.20
Individual + Child(ren)	$1,665.93	$1,701.14	$1,568.42
Family	$2,792.89	$2,851.91	$2,629.41
Plan Details			
Network	Blue Access	PPO/EPO	Blue Access
National Access via Bluecard Program	Yes	Yes	Yes
Gatekeeper	No	No	No
Rx Network	Base Rx	Base Rx	Base Rx
Formulary	Select	Traditional Open	Select
MA Creditability Coverage Status	No	Yes	Yes
Embedded / Non-Embedded Medical Deductible	Embedded	Not Embedded	Not Embedded
Medicare Part D Creditable Coverage Status	Yes	Yes	Yes
Plan Benefits			
Deductible (Ind / Fam)	$4,000 / $8,000	$4,100 / $8,200	$4,100 / $8,200
Coinsurance	40%	30%	30%
Out of Pocket Max (Ind / Fam)	$9,800 / $19,600	$8,450 / $16,900	$8,450 / $16,900
PCP / Preferred PCP	$40	Ded, then $20 Copay	Ded, then $20 Copay
Virtual Telehealth (LiveHealth Online)	No Charge	Ded, then No Charge	Ded, then No Charge
Specialist / Preferred Specialist	$80	Ded, then $50 Copay	Ded, then $50 Copay
Emergency Room	Ded, then 50%	Ded, then 30%	Ded, then 30%
Urgent Care	$125	Ded, then $100 Copay	Ded, then $100 Copay
Inpatient Facility	Ded, then 40%	Ded, then 30%	Ded, then 30%
Ambulatory Surgical Center / Outpatient Facility Surgery	Ded, then $500 Copay / Ded, then 40%	Ded, then 30%	Ded, then 30%
Preferred Lab	No Charge	Ded, then 30%	Ded, then 30%
Lab (Office / Outpatient Hospital)	$20 / $25	Ded, then 30% / Ded, then 30%	Ded, then 30% / Ded, then 30%
X-Ray (Office / Outpatient Hospital)	$75 / Ded, then 40%	Ded, then 30% / Ded, then 30%	Ded, then 30% / Ded, then 30%
Adv Diagnostic Imaging (Office / Outpatient Hospital)	$150 / Ded, then 40%	Ded, then 30% / Ded, then 30%	Ded, then 30% / Ded, then 30%
Rx Deductible (Tiers 2 & 3 only, unless specified)	$200 (IND) / $400 (FAM)	Med Ded [Tiers 1-3]	Med Ded [Tiers 1-3]
Rx Copay (Tier 1 / 2 / 3)	$15 / $65 / 50%	$10 / $50 / $90	$10 / $50 / $90

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Q1 2026 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 35/80 4650 50%	Anthem Guided Advantage Silver EPO 35/65/50/100 5000 50%	Anthem Guided Advantage Silver Blue Access EPO 35/65/50/100 5000 50%
Contract Code	93C3	93BE	93C4
Premium			
Individual	$954.52	$1,020.21	$939.71
Individual + Spouse	$1,909.04	$2,040.42	$1,879.42
Individual + Child(ren)	$1,622.68	$1,734.36	$1,597.51
Family	$2,720.38	$2,907.60	$2,678.17

Plan Name	Anthem Silver Blue Access EPO 35/80 4650 50% WH	Anthem Guided Advantage Silver EPO 35/65/50/100 5000 50% WH	Anthem Guided Advantage Silver Blue Access EPO 35/65/50/100 5000 50% WH
Contract Code	93BU	93CV	93CC
Enhanced Embedded Dental and Vision Premium			
Individual	$975.11	$1,042.30	$960.42
Individual + Spouse	$1,950.22	$2,084.60	$1,920.84
Individual + Child(ren)	$1,657.69	$1,771.91	$1,632.71
Family	$2,779.06	$2,970.56	$2,737.20
Plan Details			
Network	Blue Access	PPO/EPO	Blue Access
National Access via Bluecard Program	Yes	Yes	Yes
Gatekeeper	No	No	No
Rx Network	Base Rx	Base Rx	Base Rx
Formulary	Select	Traditional Open	Select
MA Creditability Coverage Status	No	No	No
Embedded / Non-Embedded Medical Deductible	Embedded	Embedded	Embedded
Medicare Part D Creditable Coverage Status	Yes	No	No
Plan Benefits			
Deductible (Ind / Fam)	$4,650 / $9,300	$5,000 / $10,000	$5,000 / $10,000
Coinsurance	50%	50%	50%
Out of Pocket Max (Ind / Fam)	$9,700 / $19,400	$9,500 / $19,000	$9,500 / $19,000
PCP / Preferred PCP	$35	$65 / $35	$65 / $35
Virtual Telehealth (LiveHealth Online)	No Charge	No Charge	No Charge
Specialist / Preferred Specialist	$80	$100 / $50	$100 / $50
Emergency Room	Ded, then 50%	Ded, then 50%	Ded, then 50%
Urgent Care	$100	$85	$85
Inpatient Facility	Ded, then 50%	Ded, then 50%	Ded, then 50%
Ambulatory Surgical Center / Outpatient Facility Surgery	Ded, then $300 Copay / Ded, then 50%	Ded, then $300 Copay / Ded, then 50%	Ded, then $300 Copay / Ded, then 50%
Preferred Lab	No Charge	No Charge	No Charge
Lab (Office / Outpatient Hospital)	$20 / $25	Tiered benefit depends on POS / Ded, then 50%	Tiered benefit depends on POS / Ded, then 50%
X-Ray (Office / Outpatient Hospital)	$75 / Ded, then 50%	$50 / Ded, then 50%	$50 / Ded, then 50%
Adv Diagnostic Imaging (Office / Outpatient Hospital)	$150 / Ded, then 50%	$150 / Ded, then 50%	$150 / Ded, then 50%
Rx Deductible (Tiers 2 & 3 only, unless specified)	$200 (IND) / $400 (FAM)	Med Ded	Med Ded
Rx Copay (Tier 1 / 2 / 3)	$20 / $75 / 50%	$15 / 50% / 50%	$15 / 50% / 50%

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Q1 2026 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 5500 50% w/HSA	Anthem Bronze EPO 25/75 6300 50% w/HSA	Anthem Bronze Blue Access EPO 25/75 6300 50% w/HSA
Contract Code	93B6	93AE	93AP
Premium			
Individual	$858.41	$925.84	$854.01
Individual + Spouse	$1,716.82	$1,851.68	$1,708.02
Individual + Child(ren)	$1,459.30	$1,573.93	$1,451.82
Family	$2,446.47	$2,638.64	$2,433.93

Plan Name	Anthem Bronze Blue Access EPO 5500 50% w/HSA WH	Anthem Bronze EPO 25/75 6300 50% w/HSA WH	Anthem Bronze Blue Access EPO 25/75 6300 50% w/HSA WH
Contract Code	93BY	93BL	93CF
Enhanced Embedded Dental and Vision Premium			
Individual	$879.11	$948.04	$874.83
Individual + Spouse	$1,758.22	$1,896.08	$1,749.66
Individual + Child(ren)	$1,494.49	$1,611.67	$1,487.21
Family	$2,505.46	$2,701.91	$2,493.27
Plan Details			
Network	Blue Access	PPO/EPO	Blue Access
National Access via Bluecard Program	Yes	Yes	Yes
Gatekeeper	No	No	No
Rx Network	Base Rx	Base Rx	Base Rx
Formulary	Select	Traditional Open	Select
MA Creditability Coverage Status	Yes	Yes	Yes
Embedded / Non-Embedded Medical Deductible	Not Embedded	Not Embedded	Not Embedded
Medicare Part D Creditable Coverage Status	No	No	No
Plan Benefits			
Deductible (Ind / Fam)	$5,500 / $11,000	$6,300 / $12,600	$6,300 / $12,600
Coinsurance	50%	50%	50%
Out of Pocket Max (Ind / Fam)	$8,450 / $16,900	$8,450 / $16,900	$8,450 / $16,900
PCP / Preferred PCP	Ded, then 50%	Ded, then $25 Copay	Ded, then $25 Copay
Virtual Telehealth (LiveHealth Online)	Ded, then No Charge	Ded, then No Charge	Ded, then No Charge
Specialist / Preferred Specialist	Ded, then 50%	Ded, then $75 Copay	Ded, then $75 Copay
Emergency Room	Ded, then 50%	Ded, then 50%	Ded, then 50%
Urgent Care	Ded, then 50%	Ded, then $100 Copay	Ded, then $100 Copay
Inpatient Facility	Ded, then 50%	Ded, then 50%	Ded, then 50%
Ambulatory Surgical Center / Outpatient Facility Surgery	Ded, then 50%	Ded, then 50%	Ded, then 50%
Preferred Lab	Ded, then 50%	Ded, then 50%	Ded, then 50%
Lab (Office / Outpatient Hospital)	Ded, then 50% / Ded, then 50%	Ded, then 50% / Ded, then 50%	Ded, then 50% / Ded, then 50%
X-Ray (Office / Outpatient Hospital)	Ded, then 50% / Ded, then 50%	Ded, then 50% / Ded, then 50%	Ded, then 50% / Ded, then 50%
Adv Diagnostic Imaging (Office / Outpatient Hospital)	Ded, then 50% / Ded, then 50%	Ded, then 50% / Ded, then 50%	Ded, then 50% / Ded, then 50%
Rx Deductible (Tiers 2 & 3 only, unless specified)	Med Ded [Tiers 1-3]	Med Ded [Tiers 1-3]	Med Ded [Tiers 1-3]
Rx Copay (Tier 1 / 2 / 3)	$10 / 50% / 50%	50% / 50% / 50%	50% / 50% / 50%

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Q1 2026 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 7500 50% w/HSA	Anthem Guided Advantage Bronze Blue Access EPO 40/70/80/120 9200 50%	Anthem Bronze Blue Access EPO 10150 0%
Contract Code	93DA	93AJ	93AW
Premium			
Individual	$845.80	$874.95	$843.26
Individual + Spouse	$1,691.60	$1,749.90	$1,686.52
Individual + Child(ren)	$1,437.86	$1,487.42	$1,433.54
Family	$2,410.53	$2,493.61	$2,403.29

Plan Name	Anthem Bronze Blue Access EPO 20/50 7500 50% w/HSA WH	Anthem Guided Advantage Bronze Blue Access EPO 40/70/80/120 9200 50% WH	Anthem Bronze Blue Access EPO 10150 0% WH
Contract Code	93C6	93AB	93CD
Enhanced Embedded Dental and Vision Premium			
Individual	$866.73	$895.88	$864.42
Individual + Spouse	$1,733.46	$1,791.76	$1,728.84
Individual + Child(ren)	$1,473.44	$1,523.00	$1,469.51
Family	$2,470.18	$2,553.26	$2,463.60

Plan Details			
Network	Blue Access	Blue Access	Blue Access
National Access via Bluecard Program	Yes	Yes	Yes
Gatekeeper	No	No	No
Rx Network	Base Rx	Base Rx	Base Rx
Formulary	Select	Select	Select
MA Creditability Coverage Status	Yes	No	No
Embedded / Non-Embedded Medical Deductible	Not Embedded	Embedded	Embedded
Medicare Part D Creditable Coverage Status	No	No	No
Plan Benefits			
Deductible (Ind / Fam)	$7,500 / $15,000	$9,200 / $18,400	$10,150 / $20,300
Coinsurance	50%	50%	0%
Out of Pocket Max (Ind / Fam)	$8,450 / $16,900	$10,150 / $20,300	$10,150 / $20,300
PCP / Preferred PCP	Ded, then $20 Copay	$70 / $40	Ded, then No Charge
Virtual Telehealth (LiveHealth Online)	Ded, then No Charge	No Charge	Ded, then No Charge
Specialist / Preferred Specialist	Ded, then $50 Copay	$120 / $80	Ded, then No Charge
Emergency Room	Ded, then 50%	Ded, then 50%	Ded, then No Charge
Urgent Care	Ded, then $100 Copay	$100	Ded, then No Charge
Inpatient Facility	Ded, then 50%	Ded, then 50%	Ded, then No Charge
Ambulatory Surgical Center / Outpatient Facility Surgery	Ded, then 50%	Ded, then $500 Copay / Ded, then 50%	Ded, then No Charge
Preferred Lab	Ded, then 50%	$70	Ded, then No Charge
Lab (Office / Outpatient Hospital)	Ded, then 50% / Ded, then 50%	Tiered benefit depends on POS / Ded, then 50%	Ded, then No Charge
X-Ray (Office / Outpatient Hospital)	Ded, then 50% / Ded, then 50%	$75 / Ded, then 50%	Ded, then No Charge
Adv Diagnostic Imaging (Office / Outpatient Hospital)	Ded, then 50% / Ded, then 50%	$175 / Ded, then 50%	Ded, then No Charge
Rx Deductible (Tiers 2 & 3 only, unless specified)	Med Ded [Tiers 1-3]	Med Ded	Med Ded [Tiers 1-3]
Rx Copay (Tier 1 / 2 / 3)	50% / 50% / 50%	$25 / 50% / 50%	N/A

For SBC(s) or SOB(s), please visit:
https://sbc.anthem.com/dps/
https://plan-summaries.anthem.com/sobdps/

1) Anthem Blue Cross and Blue Shield is the trade name of Anthem HealthChoice HMO, Inc. and Anthem HealthChoice Assurance, Inc. Anthem Blue Cross and Blue Shield 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.
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