2021 CREBP Benefit Summaries

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CREBP Anthem Prudent Buyer Network PPO Plans

Plan name	Anthem Platinum PPO 5/250/15%	Anthem Platinum PPO 15/250/10%	Anthem Platinum PPO 20/10%	Anthem Gold PPO 5/1500/30%	Anthem Gold PPO 20/30%	Anthem Gold Select PPO 30/500/20%
Network	Prudent Buyer PPO	Prudent Buyer PPO	Prudent Buyer PPO	Prudent Buyer PPO	Prudent Buyer PPO	Prudent Buyer PPO
Plan Code	5SVU	5SRR	5SXU	5SRR	5SXU	5SY2
Deductible (individual/family)	$250 person / $750 family	$250 person / $750 family	$0 person / $0 family	$1,500 person / $3,000 family	$0 person / $0 family	$500 person / $1,500 family
Out-of-pocket maximum (individual/family)	$4,000 person / $8,000 family	$4,000 person / $8,000 family	$4,000 person / $8,000 family	$7,500 person / $15,000 family	$7,400 person / $14,800 family	$7,500 person / $15,000 family
Coinsurance	15%	10%	10%	30%	30%	20%
Office visits: Primary care/Specialist	$5 / $45	$15 / $30	$20 / $40	$5 / $65	$20 / $50	$30 / $60
Doctor Visits: Online - Televisits	$0 for first 3 visits, then $5	$0 for first 3 visits, then $5	$0 for first 3 visits, then $5	$0 for first 3 visits, then $5	$0 for first 3 visits, then $5	$0 for first 3 visits, then $5
Preventive Exams/Benefits	No charge	No charge	No charge	No charge	No charge	No charge
X-Ray and Lab: Most labs and imaging	$10 copay	$10 copay	$10 copay	$15 copay	$15 copay	$15 copay
X-Ray and Lab: MRI/CT/PET Scan	15% coinsurance after deductible	10% coinsurance after deductible	10% coinsurance	30% coinsurance after deductible	30% coinsurance	20% coinsurance after deductible
Inpatient Hospitalization	15% coinsurance after deductible	10% coinsurance after deductible	10% coinsurance	30% coinsurance after deductible	30% coinsurance	20% coinsurance after deductible
Outpatient Surgery	$200 copay per visit and 15% coinsurance after deductible	$200 copay per visit and 10% coinsurance after deductible	$150 copay per visit and 10% coinsurance	$200 copay per visit and 30% coinsurance after deductible	$200 copay per visit and 30% coinsurance	$200 copay per visit and 20% coinsurance after deductible
Ambulance Services	15% coinsurance after deductible	10% coinsurance after deductible	10% coinsurance	30% coinsurance after deductible	30% coinsurance	20% coinsurance after deductible
Emergency Room (facility)	$250 copay per visit and 15% coinsurance after deductible	$200 copay per visit and 10% coinsurance after deductible	$200 copay per visit and 10% coinsurance	$250 copay per visit and 30% coinsurance after deductible	$250 copay per visit and 30% coinsurance	$250 copay per visit and 20% coinsurance after deductible
Urgent care (facility)	$45 copay per visit	$30 copay per visit	$40 copay per visit	$65 copay per visit	$50 copay per visit	$60 copay
Pharmacy deductible (individual/family)[1]	Not applicable	Not applicable	Not applicable	$250 person / $500 family (Tiers 2-4)	$150 person / $300 family (Tiers 2-4)	$200 person / $400 family (Tiers 2-4)
RX Co-Pays: Generic[1]	$5 Preferred Network Provider / $15 In-Network Provider	$10 Preferred Network Provider / $20 In-Network Provider	$10 Preferred Network Provider / $20 In-Network Provider	$5 Preferred Network Provider / $15 In-Network Provider	$15 Preferred Network Provider / $25 In-Network Provider	$15 Preferred Network Provider / $25 In-Network Provider
RX Co-Pays: Brand Name[1]	$35 Preferred Network Provider / $50 In-Network Provider	$35 Preferred Network Provider / $50 In-Network Provider	$35 Preferred Network Provider / $50 In-Network Provider	$50 Preferred Network Provider / $75 In-Network Provider	$45 Preferred Network Provider / $65 In-Network Provider	$45 Preferred Network Provider / $65 In-Network Provider
RX Co-Pays: Specialty	Refer to Formulary/Drug Lists and SOB	Refer to Formulary/Drug Lists and SOB	Refer to Formulary/Drug Lists and SOB	Refer to Formulary/Drug Lists and SOB	Refer to Formulary/Drug Lists and SOB	Refer to Formulary/Drug Lists and SOB
Certain Durable Medical Equipment (DME)	50% coinsurance after deductible	50% coinsurance after deductible	50% coinsurance	50% coinsurance after deductible	50% coinsurance	50% coinsurance after deductible
Pediatric Dental	Included - refer to SOB	Included - refer to SOB	Included - refer to SOB	Included - refer to SOB	Included - refer to SOB	Included - refer to SOB
Adult Vision Exam	$20 copay	$20 copay	$20 copay	$20 copay	$20 copay	$20 copay
Optical Eye Wear	Not covered	Not covered	Not covered	Not covered	Not covered	Not covered

1 Refer to the Anthem Select Formulary/Drug List for details on the drug and Tier.

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CREBP Anthem Prudent Buyer Network PPO Plans

Plan name	Anthem Gold PPO 30/750/20%	Anthem Gold PPO 35/500/25%	Anthem Gold PPO 35/1000/20%	Anthem Silver PPO 45/1750/40%	Anthem Silver PPO 50/2200/40%	Anthem Silver PPO 55/1850/35%
Network	Prudent Buyer PPO	Prudent Buyer PPO	Prudent Buyer PPO	Prudent Buyer PPO	Prudent Buyer PPO	Prudent Buyer PPO
Plan Code	5SYU	5SQT	5SZ2	5SZA	5SYL	2LHZ
Deductible (individual/family)	$750 person / $2,250 family	$500 person / $1,500 family	$1,000 person / $3,000 family	$1,750 person / $3,500 family	$2,200 person / $4,400 family	$1,850 person / $3,700 family
Out-of-pocket maximum (individual/family)	$7,800 person / $15,600 family	$7,800 person / $15,600 family	$7,800 person / $15,600 family	$8,100 person / $16,200 family	$8,150 person / $16,300 family	$8,500 person / $17,000 family
Coinsurance	20%	25%	20%	40%	40%	35%
Office visits: Primary care/Specialist	$30 / $55	$35 / $65	$35 / $60	$45 / $95	$50 / $85	$55 / $85
Doctor Visits: Online - Televisits	$0 for first 3 visits, then $5	$0 for first 3 visits, then $5	$0 for first 3 visits, then $5	$0 for first 3 visits, then $5	$0 for first 3 visits, then $5	$0 for first 3 visits, then $5
Preventive Exams/Benefits	No charge	No charge	No charge	No charge	No charge	No charge
X-Ray and Lab: Most labs and imaging	$15 copay	$15 copay	$15 copay	$20 copay	$20 copay	$20 copay
X-Ray and Lab: MRI/CT/PET Scan	20% coinsurance after deductible	25% coinsurance after deductible	20% coinsurance after deductible	40% coinsurance after deductible	40% coinsurance after deductible	35% coinsurance after deductible
Inpatient Hospitalization	20% coinsurance after deductible	25% coinsurance after deductible	20% coinsurance after deductible	40% coinsurance after deductible	40% coinsurance after deductible	35% coinsurance after deductible
Outpatient Surgery	$200 copay per visit and 20% coinsurance after deductible	$200 copay per visit and 25% coinsurance after deductible	$200 copay per visit and 20% coinsurance after deductible	$200 copay per visit and 40% coinsurance after deductible	$200 copay per visit and 40% coinsurance after deductible	$200 copay per visit and 35% coinsurance after deductible
Ambulance Services	20% coinsurance after deductible	25% coinsurance after deductible	20% coinsurance after deductible	40% coinsurance after deductible	40% coinsurance after deductible	35% coinsurance after deductible
Emergency Room (facility)	$250 copay per visit and 20% coinsurance after deductible	$250 copay per visit and 25% coinsurance after deductible	$250 copay per visit and 20% coinsurance after deductible	$300 copay per visit and 40% coinsurance after deductible	$350 copay per visit and 40% coinsurance after deductible	$350 copay per visit and 35% coinsurance after deductible
Urgent care (facility)	$55 copay	$65 copay	$60 copay	$95 copay	$85 copay	$85 copay
Pharmacy deductible (individual/family)[1]	$250 person / $500 family (Tiers 2-4)	$250 person / $500 family (Tiers 2-4)	$250 person / $500 family (Tiers 2-4)	$300 person / $600 family (Tiers 2-4)	$250 person / $500 family (Tiers 2-4)	$300 person / $600 family (Tiers 2-4)
RX Co-Pays: Generic[1]	$15 Preferred Network Provider / $25 In-Network Provider	$15 Preferred Network Provider / $25 In-Network Provider	$15 Preferred Network Provider / $25 In-Network Provider	$20 Preferred Network Provider / $25 In-Network Provider	$20 Preferred Network Provider / $25 In-Network Provider	$20 Preferred Network Provider / $25 In-Network Provider
RX Co-Pays: Brand Name[1]	$45 Preferred Network Provider / $65 In-Network Provider	$45 Preferred Network Provider / $65 In-Network Provider	$45 Preferred Network Provider / $65 In-Network Provider	$60 Preferred Network Provider / $95 In-Network Provider	$60 Preferred Network Provider / $100 In-Network Provider	$60 Preferred Network Provider / $95 In-Network Provider
RX Co-Pays: Specialty	Refer to Formulary/Drug Lists and SOB	Refer to Formulary/Drug Lists and SOB	Refer to Formulary/Drug Lists and SOB	Refer to Formulary/Drug Lists and SOB	Refer to Formulary/Drug Lists and SOB	Refer to Formulary/Drug Lists and SOB
Certain Durable Medical Equipment (DME)	50% coinsurance after deductible	50% coinsurance after deductible	50% coinsurance after deductible	50% coinsurance after deductible	50% coinsurance after deductible	50% coinsurance after deductible
Pediatric Dental	Included - refer to SOB	Included - refer to SOB	Included - refer to SOB	Included - refer to SOB	Included - refer to SOB	Included - refer to SOB
Adult Vision Exam	$20 copay	$20 copay	$20 copay	$20 copay	$20 copay	$20 copay
Optical Eye Wear	Not covered	Not covered	Not covered	Not covered	Not covered	Not covered

1 Refer to the Anthem Select Formulary/Drug List for details on the drug and Tier.

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CREBP Anthem Prudent Buyer Network PPO Plans

Plan name	Anthem Silver PPO 55/2500/45%	Anthem Silver PPO 2000/30% w/HSA - RxC	Anthem Silver PPO 2500/35% w/HSA PrevRx	Anthem Bronze PPO 40/5600/40%	Anthem Bronze PPO 60/6350/40%	Anthem Bronze PPO 70/6600/35%
Network	Prudent Buyer PPO	Prudent Buyer PPO	Prudent Buyer PPO	Prudent Buyer PPO	Prudent Buyer PPO	Prudent Buyer PPO
Plan Code	5SR1	5SW5 (Single) 5SWD (Family)	5T0V (Single) 5T0Z (Family)	5SWH	5SSR	5SXL
Deductible (individual/family)	$2,500 person / $5,000 family	$2,000 person / $2,800 person in a family / $4,000 family	$2,500 person / $2,800 person in a family / $5,000 family	$5,600 person / $11,200 family	$6,350 person / $12,700 family	$6,600 person / $13,200 family
Out-of-pocket maximum (individual/family)	$8,150 person / $16,300 family	$6,750 person / $13,500 family	$6,950 person / $13,900 family	$8,400 person / $16,800 family	$8,150 person / $16,300 family	$8,550 person / $17,100 family
Coinsurance	45%	30%	35%	40%	40%	35%
Office visits: Primary care/Specialist	$55 / $85	30% coinsurance after deductible	35% coinsurance after deductible	$40 / $80 copay after deductible	$60 / $80 after deductible	$70 / $85 after deductible
Doctor Visits: Online - Televisits	$0 for first 3 visits, then $5	30% coinsurance after deductible	35% coinsurance after deductible	No charge for the first 12 visits and then $5 copay	No charge for the first 12 visits and then $5 copay	No charge for the first 12 visits and then $5 copay
Preventive Exams/Benefits	No charge	No charge	No charge	No charge	No charge	No charge
X-Ray and Lab: Most labs and imaging	$20 copay	30% coinsurance after deductible	35% coinsurance after deductible	40% coinsurance after deductible	40% coinsurance after deductible	35% coinsurance after deductible
X-Ray and Lab: MRI/CT/PET Scan	45% coinsurance after deductible	30% coinsurance after deductible	35% coinsurance after deductible	40% coinsurance after deductible	40% coinsurance after deductible	35% coinsurance after deductible
Inpatient Hospitalization	45% coinsurance after deductible	30% coinsurance after deductible	35% coinsurance after deductible	40% coinsurance after deductible	40% coinsurance after deductible	35% coinsurance after deductible
Outpatient Surgery	$200 copay per visit and 45% coinsurance after deductible	$200 copay per visit and 30% coinsurance after deductible	$200 copay per visit and 35% coinsurance after deductible	$200 copay per visit and 40% coinsurance after deductible	$200 copay per visit and 40% coinsurance after deductible	$200 copay per visit and 35% coinsurance after deductible
Ambulance Services	45% coinsurance after deductible	30% coinsurance after deductible	35% coinsurance after deductible	40% coinsurance after deductible	40% coinsurance after deductible	35% coinsurance after deductible
Emergency Room (facility)	$100 copay per visit and 45% coinsurance after deductible	30% coinsurance after deductible	35% coinsurance after deductible	$250 copay per visit and 40% coinsurance after deductible	$250 copay per visit and 40% coinsurance after deductible	$250 copay per visit and 35% coinsurance after deductible
Urgent care (facility)	$85 copay	30% coinsurance after deductible	35% coinsurance after deductible	40% coinsurance after deductible	40% coinsurance after deductible	35% coinsurance after deductible
Pharmacy deductible (individual/family)[1]	Not applicable	Combined with InNetwork medical deductible	Combined with InNetwork medical deductible	Combined with InNetwork medical deductible	$625 person / $1,250 family (Tiers 2-4)	Combined with InNetwork medical deductible
RX Co-Pays: Generic[1]	$20 Preferred Network Provider / $25 In-Network Provider	$20 Preferred Network Provider / $25 In-Network Provider	$20 Preferred Network Provider / $25 In-Network Provider	$20 Preferred Network Provider / $25 In-Network Provider	$20 Preferred Network Provider / $25 In-Network Provider	$20 Preferred Network Provider / $25 In-Network Provider
RX Co-Pays: Brand Name[1]	$65 Preferred Network Provider / $100 In-Network Provider	$60 Preferred Network Provider / $95 In-Network Provider	$65 Preferred Network Provider / $100 In-Network Provider	$70 Preferred Network Provider / $115 In-Network Provider	$65 Preferred Network Provider / $100 In-Network Provider	$70 Preferred Network Provider / $115 In-Network Provider
RX Co-Pays: Specialty	Refer to Formulary/Drug Lists and SOB	Refer to Formulary/Drug Lists and SOB	Refer to Formulary/Drug Lists and SOB	Refer to Formulary/Drug Lists and SOB	Refer to Formulary/Drug Lists and SOB	Refer to Formulary/Drug Lists and SOB
Certain Durable Medical Equipment (DME)	50% coinsurance after deductible	50% coinsurance after deductible	50% coinsurance after deductible	50% coinsurance after deductible	50% coinsurance after deductible	50% coinsurance after deductible
Pediatric Dental	Included - refer to SOB	Included - refer to SOB	Included - refer to SOB	Included - refer to SOB	Included - refer to SOB	Included - refer to SOB
Adult Vision Exam	$20 copay	$20 copay	$20 copay	$20 copay	$20 copay	$20 copay
Optical Eye Wear	Not covered	Not covered	Not covered	Not covered	Not covered	Not covered

1 Refer to the Anthem Select Formulary/Drug List for details on the drug and Tier.

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CREBP Anthem Prudent Buyer Network PPO Plans

Plan name	Anthem Bronze PPO 75/7300/40%	Anthem Bronze PPO 4600/50%	Anthem Bronze PPO 5600/45% w/HSA	Anthem Bronze PPO 6950/0% w/HSA
Network	Prudent Buyer PPO	Prudent Buyer PPO	Prudent Buyer PPO	Prudent Buyer PPO
Plan Code	5T09	5SR9	5STX	5SU5
Deductible (individual/family)	$7,300 person / $14,600 family	$4,600 person / $9,200 family	$5,600 person / $11,200 family	$6,950 person / $13,900 family
Out-of-pocket maximum (individual/family)	$8,550 person / $17,100 family	$8,100 person / $16,200 family	$7,000 person / $14,000 family	$6,950 person / $13,900 family
Coinsurance	40%	50%	45%	0% coinsurance after deductible
Office visits: Primary care/Specialist	$75 / $110 after deductible	50% coinsurance after deductible	45% coinsurance after deductible	0% coinsurance after deductible
Doctor Visits: Online - Televisits	No charge for the first 12 visits and then $5 copay	50% coinsurance after deductible	45% coinsurance after deductible	0% coinsurance after deductible
Preventive Exams/Benefits	No charge	No charge	No charge	No charge
X-Ray and Lab: Most labs and imaging	$25 copay	50% coinsurance after deductible	45% coinsurance after deductible	0% coinsurance after deductible
X-Ray and Lab: MRI/CT/PET Scan	40% coinsurance after deductible	50% coinsurance after deductible	45% coinsurance after deductible	0% coinsurance after deductible
Inpatient Hospitalization	40% coinsurance after deductible	50% coinsurance after deductible	45% coinsurance after deductible	0% coinsurance after deductible
Outpatient Surgery	$200 copay per visit and 40% coinsurance after deductible	50% coinsurance after deductible	$200 copay per visit and 45% coinsurance after deductible	0% coinsurance after deductible
Ambulance Services	40% coinsurance after deductible	50% coinsurance after deductible	45% coinsurance after deductible	0% coinsurance after deductible
Emergency Room (facility)	$250 copay per visit and 40% coinsurance after deductible	50% coinsurance after deductible	45% coinsurance after deductible	0% coinsurance after deductible
Urgent care (facility)	$110 copay	50% coinsurance after deductible	45% coinsurance after deductible	0% coinsurance after deductible
Pharmacy deductible (individual/family)[1]	$750 person / $1,500 family (Tiers 2-4)	Combined with InNetwork medical deductible	Combined with InNetwork medical deductible	Combined with InNetwork medical deductible
RX Co-Pays: Generic[1]	$25 Preferred Network Provider / $115 In-Network Provider	40% coinsurance after deductible	35% coinsurance after deductible	0% coinsurance after deductible
RX Co-Pays: Brand Name[1]	$25 Preferred Network Provider / $130 In-Network Provider	50% coinsurance after deductible	45% coinsurance after deductible	0% coinsurance after deductible
RX Co-Pays: Specialty	Refer to Formulary/Drug Lists and SOB	Refer to Formulary/Drug Lists and SOB	Refer to Formulary/Drug Lists and SOB	Refer to Formulary/Drug Lists and SOB
Certain Durable Medical Equipment (DME)	50% coinsurance after deductible	50% coinsurance after deductible	50% coinsurance after deductible	0% coinsurance after deductible
Pediatric Dental	Included - refer to SOB	Included - refer to SOB	Included - refer to SOB	Included - refer to SOB
Adult Vision Exam	$20 copay	$20 copay	$20 copay	$20 copay
Optical Eye Wear	Not covered	Not covered	Not covered	Not covered

1 Refer to the Anthem Select Formulary/Drug List for details on the drug and Tier.