# Zempleo HMO Plan Comparison

| | | Anthem HMO Plans - California Only | | | | | | |
|---|---|---|---|---|---|---|---|---|
| **Plan Name** | | **CA BASE PLAN Gold HMO 30 7ZYW** | **Gold HMO 30 7ZYV** | **Gold HMO 35 7ZZB** | **Gold HMO 35/1250/20% 802Q** | **Platinum HMO 0/20 800N** | **Platinum HMO 0/25 800V** | **Platinum HMO 0/25 800S** |
| **Network Name** | | Select HMO | CaliforniaCare HMO | Select HMO | Select HMO | Select HMO | Select HMO | CaliforniaCare HMO |
| **Deductible** | Individual | $0 | $0 | $0 | $1,250 | $0 | $0 | $0 |
| | Family | $0 | $0 | $0 | $2,500 | $0 | $0 | $0 |
| **Out-of-Pocket Max** | Individual | $7,500 | $7,500 | $6,750 | $8,600 | $1,900 | $2,300 | $2,300 |
| | Family | $15,000 | $15,000 | $13,500 | $17,200 | $3,800 | $4,600 | $4,600 |
| **Office Visits (PCP / SPC)** | | $30 Copay/$60 Copay | $30 Copay/$60 Copay | $35 Copay/$70 Copay | $35 Copay/$60 Copay | $20 Copay/$40 Copay | $25 Copay/$50 Copay | $25 Copay/$50 Copay |
| **Lab work** | | $15/No Charge/$25 | $15/No Charge/$25 | $15/No Charge/$30 | $15/No Charge/20% * | $10/No Charge/$15 | $10/No Charge/$15 | $10/No Charge/$15 |
| **X-rays** | | $15/$15/$45 | $15/$15/$45 | $15/$15/$45 | $15/$15/20% * | $10/$10/$30 | $10/$10/$30 | $10/$10/$30 |
| **Advanced Radiology** | | $100/$100/$250 | $100/$100/$250 | $100/$100/$250 | $200/$200/$350 * | $100/$100/$250 | $100/$100/$250 | $100/$100/$250 |
| **Hospital Services (In-Patient)** | | $600 Per Day Copay up to 4 days | $600 Per Day Copay up to 4 days | $750 Per Day Copay up to 4 Days | 20% * | $500/Admit | $300 Per Day Copay up to 3 Days | $300 Per Day Copay up to 3 Days |
| **Hospital Services (Out-Patient)** | | $300 Copay/$450 Copay | $300 Copay/$450 Copay | $450 Copay/$550 Copay | $500 Copay/20% * | $100 Copay/$150 Copay | $150 Copay/$200 Copay | $150 Copay/$200 Copay |
| **Urgent Care** | | $30 Copay | $30 Copay | $35 Copay | $35 Copay | $20 Copay | $25 Copay | $25 Copay |
| **Emergency Room** | | $325 Copay | $325 Copay | $325 Copay | $300 Copay + 20% * | $250 Copay | $275 Copay | $275 Copay |
| **Prescription Drugs** | | | | | | | | |
| **Generic / Tier 1** | | $10 Copay/$20 Copay | $10 Copay/$20 Copay | $10 Copay/$20 Copay | $10 Copay/$20 Copay | $5 Copay/$15 Copay | $5 Copay/$15 Copay | $5 Copay/$15 Copay |
| **Brand / Tier 2** | | $50 Copay/$60 Copay | $50 Copay/$60 Copay | $50 Copay/$60 Copay | $50 Copay/$60 Copay | $20 Copay/$30 Copay | $20 Copay/$30 Copay | $20 Copay/$30 Copay |
| **Non-Formulary / Tier 3** | | $90 Copay/$100 Copay | $90 Copay/$100 Copay | $90 Copay/$100 Copay | $90 Copay/$100 Copay | $50 Copay/$60 Copay | $50 Copay/$60 Copay | $50 Copay/$60 Copay |
| **Specialty / Tier 4** | | 30%/40% up to $250 | 30%/40% up to $250 | 30%/40% up to $250 | 30%/40% up to $250 | 30%/40% up to $250 | 30%/40% up to $250 | 30%/40% up to $250 |

* Deductible applies

# Zempleo PPO Plan Comparison

| | | Anthem PPO Plans - California & Non-California | | | | | |
|---|---|---|---|---|---|---|---|
| **Plan Name** | | **Non-CA BASE PLAN<br>Gold PPO<br>35/500/25% 806B** | | **Gold PPO<br>35/1000/20% 807D** | | **Gold PPO<br>35/500/25% 8067** | |
| **Network Name** | | Prudent Buyer PPO | | Select PPO | | Select PPO | |
| **Deductible** | Individual | $500 | $2,000 | $1,000 | $2,000 | $500 | $2,000 |
| | Family | $1,500 | $4,000 | $3,000 | $4,000 | $1,500 | $4,000 |
| **Out-of-Pocket Max** | Individual | $8,200 | $16,400 | $8,200 | $16,400 | $8,200 | $16,400 |
| | Family | $16,400 | $32,800 | $16,400 | $32,800 | $16,400 | $32,800 |
| **Coinsurance** | | 25% | 50% | 20% | 50% | 25% | 50% |
| **Office Visits (PCP / SPC)** | | $35 Copay/$65 Copay | Ded, then 50% | $35 Copay/$60 Copay | Ded, then 50% | $35 Copay/$65 Copay | Ded, then 50% |
| **Lab work** | | $15/No Charge/25% * | Ded, then 50% | $15/No Charge/20% * | Ded, then 50% | $15/No Charge/25% * | Ded, then 50% |
| **X-rays** | | $15/25%/25% * | Ded, then 50% | $15/20%/20% * | Ded, then 50% | $15/25%/25% * | Ded, then 50% |
| **Advanced Radiology** | | 25%/25%/$100 + 25% * | Ded, then 50% | 20%/20%/$100 + 20% * | Ded, then 50% | 25%/25%/$100 + 25% * | Ded, then 50% |
| **Hospital Services (In-Patient)** | | 25% * | Ded, then 50% | 20% * | Ded, then 50% | 25% * | Ded, then 50% |
| **Hospital Services (Out-Patient)** | | 25%/$250 + 25%/$50 * | 50%/50%-Max $380 * | 20%/$250 + 20%/$50 * | 50%/50%-Max $380 * | 25%/$250 + 25%/$50 * | 50%/50%-Max $380 * |
| **Urgent Care** | | $35 Copay | Ded, then 50% | $35 Copay | Ded, then 50% | $35 copay | Ded, then 50% |
| **Emergency Room** | | $250 Copay + 25% * | | $250 Copay + 20% * | | $250 Copay + 25% | |
| **Prescription Drugs** | | **Pharmacy Ded: $250 Ind./ $500 Fam** | | **Pharmacy Ded: $300 Ind./ $600 Fam** | | **Pharmacy Ded: $250 Ind./ $500 Fam** | |
| **Generic / Tier 1** | | $10 Copay/$20 Copay | Not Covered | $5 Copay/$15 Copay | Not Covered | $10 Copay/$20 Copay | Not Covered |
| **Brand / Tier 2** | | $50 Copay/$60 Copay * | | $60 Copay/$70 Copay * | | $50 Copay/$60 Copay * | |
| **Non-Formulary / Tier 3** | | $90 Copay/$100 Copay * | | $110 Copay/$120 Copay * | | $90 Copay/$100 Copay * | |
| **Specialty / Tier 4** | | 30%/40% up to $250 * | | 30%/40% up to $250 * | | 30%/40% up to $250 * | |

* Deductible applies