Side By Side Comparison

Test Group

Effective October 01, 2021

Zip Code 94597 - Contra Costa

	Anthem Blue Cross PPO Platinum PPO 15/250/10% 5SYC **Broad Network**	Anthem Blue Cross PPO Platinum PPO 20/10% 5SVU **Broad Network**	Anthem Blue Cross PPO Platinum PPO 5/250/15% 5SRH **Broad Network**	Anthem Blue Cross PPO Platinum PPO 5/250/15% WH 5SZF **Broad Network**
Deductible In Net	$250	$0	$250	$250
Out Net	$2,000	$2,000	$2,000	$2,000
PC/Specialist In Net	$15/$30 ded waived	$20/$40	$5/$45 ded waived	$5/$45 ded waived
Out Net	50% after ded	50% after ded	50% after ded	50% after ded
Co-Insurance In Net	10%	10%	15%	15%
Out Net	50%	50%	50%	50%
OOP Limit In Net	$4,000 (incl ded)	$4,000	$4,000 (incl ded)	$4,000 (incl ded)
Out Net	$8,000 (incl ded)	$8,000 (incl ded)	$8,000 (incl ded)	$8,000 (incl ded)
Family OOP Limit In Net	$8,000 (incl ded)	$8,000	$8,000 (incl ded)	$8,000 (incl ded)
Out Net	$16,000 (incl ded)	$16,000 (incl ded)	$16,000 (incl ded)	$16,000 (incl ded)
Lab/X-Ray In Net	Lab-No charge (FS)/$10 ded waived (Office)/10% after ded (OP Hosp); X-ray-10% after ded (FS & OP Hosp)/$10 ded waived (Office)	Lab-No charge (FS)/$10 (Offfice)/10% (OP Hosp); X-ray-10% (FS & OP Hosp)/$10 (Office)	Lab-No charge (FS)/$10 ded waived (Office)/15% after ded (OP Hosp); X-ray-15% after ded (FS & OP Hosp)/$10 ded waived (Office)	Lab-No charge (FS)/$10 ded waived (Office)/15% after ded (OP Hosp); X-ray-15% after ded (FS & OP Hosp)/$10 ded waived (Office)
Out Net	50% after ded	50% after ded	50% after ded	50% after ded
Inpatient Hosp In Net	10% after ded	10%	15% after ded	15% after ded
Out Net	50% after ded; $650 benefit max/day	50% after ded; $650 benefit max/day	50% after ded; $650 benefit max/day	50% after ded; $650 benefit max/day
Urgent Care In Net	$30 ded waived	$40	$45 ded waived	$45 ded waived
Out Net	50% after ded	50% after ded	50% after ded	50% after ded
Rx Generic In Net	$10/$20 ded waived	$10/$20	$5/$15 ded waived	$5/$15 ded waived
Out Net	Not covered	Not covered	Not covered	Not covered
Rx Preferred In Net	$35/$50 ded waived	$35/$50	$35/$50 ded waived	$35/$50 ded waived
Out Net	Not covered	Not covered	Not covered	Not covered
Rx Non-Preferred In Net	$70/$85 ded waived	$70/$85	$70/$85 ded waived	$70/$85 ded waived
Out Net	Not covered	Not covered	Not covered	Not covered
EE's Included	**7/7**	**7/7**	**7/7**	**7/7**
EE Cost	**$5,994.65**	**$6,138.56**	**$5,913.37**	**$6,132.69**
Dep Cost	**$2,932.55**	**$3,002.97**	**$2,892.81**	**$3,000.08**
Total	**$8,927.20**	**$9,141.53**	**$8,806.18**	**$9,132.77**

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