City of San José Office of Retirement Services 2024 Commercial **(Non-Medicare)** Plan Comparison

CITY OF SAN JOSE CAPITAL OF SILICON VALLEY	Kaiser (California only) $3200 High Deductible HMO	Kaiser (California Only) $1500 Deductible HMO	Kaiser (California Only) $25 Copay HMO	Anthem (California only) $20 Copay Select HMO	Anthem (California only) $20 Copay Traditional HMO	Anthem (California only) $1500 Deductible Select HMO	Anthem (Nationwide) $100 Deductible Select PPO In-Network	Anthem (Nationwide) $100 Deductible Select PPO Out-Of-Network	Anthem (Nationwide) $100 Deductible Classic PPO In-Network	Anthem (Nationwide) $100 Deductible Classic PPO Out-of-Network	Anthem (Nationwide) $2500 High Deductible Classic PPO In-Network	Anthem (Nationwide) $2500 High Deductible Classic PPO Out-of-Network
Phone: Group Number: Website:	1-800-464-4000 Group #887 NorCal Group #230179 SoCal www.kp.org	1-800-464-4000 Group #887 NorCal Group #230179 SoCal www.kp.org	1-800-464-4000 Group #887 NorCal Group #230179 SoCal www.kp.org	1-844-963-0448 Group #282397H025 www.Anthem.com/ca/csj	1-844-963-0448 Group #282397H073 www.Anthem.com/ca/csj	1-844-963-0448 Group #282397H026 www.Anthem.com/ca/csj	1-844-963-0448 Group #282397M033 www.Anthem.com/ca/csj		1-844-963-0448 Group #282397M034 www.Anthem.com/ca/csj		1-844-860-3535* (*This phone number is for $2500 High Deductible Plan only) Group #282397H025 www.Anthem.com/ca/csj	
	Monthly Premium	**Monthly Premium:**	**Monthly Premium:**	**Monthly Premium**	**Monthly Premium**	**Monthly Premium**	**Monthly Premium**		**Monthly Premium**		**Monthly Premium**	
Member Only	$0.00/Month	$111.54/Month	$268.28/Month	$343.40/Month	$484.04/Month	$128.04/Month	$2087.56/Month		$2274.22/Month		$1056.88/Month	
Member+ Spouse/DP	$0.00/Month	$223.06/Month	$536.54/Month	$874.80/Month	$1184.22/Month	$401.10/Month	$4712.06/Month		$5122.68/Month		$2444.50/Month	
Member+ Child(ren)	$0.00/Month	$195.20/Month	$469.48//Month	$647.96/Month	$901.14/Month	$260.32/Month	$3787.50/Month		$4123.42/Month		$1932.24/Month	
Member+ Spouse/DP+ Child(ren)	$0.00/Month	$334.60/Month	$804.82/Month	$1124.12/Month	$1560.16/Month	$456.66/Month	$6531.26/Month		$7109.76/Month		$3336.06/Month	
Annual Deductible (Calendar Year)	$3,200 Individual $3,200 Member $6,400 Family	$1,500 Individual $1,500 Member $3,000 Family No Deductible for Primary, Specialistand Preventive visits	None	None	None	$1,500 Individual $1,500 Member $3,000 Family	$100 Individual $200 Family	$100 Individual $200 Family	$100 Individual $200 Family	$100 Individual $200 Family	$2,500 Individual $3,200 Member $5,000 Family	$2,500 Individual $3,200 Member $5,000 Family
Annual Out-of-Pocket Maximum Single Per member in family Family	$5,950/year $5,950/year $11,900/year	$4,000/year $4,000/year $8,000/year	$1,500/year $1,500/year $3,000/year	$1,500/year $1,500/year $3,000/year	$1,500/year $1,500/year $3,000/year	$4,000 Individual $4,000 Member $8,000 Family	$2,100/year $4,200/year	$2,100/year $4,200/year	$2,100/year $4,200/year	$2,100/year $4,200/year	$4,000 Individual $4,000 Member $8,000 Family	$9,000 Individual $9,000 Member $18,000 Family
Physician Office Visit	30% after deductible	$40 copay per visit	$25 copay per visit	$20 copay per visit	$20 copay per visit	$20 copay per visit	$25 copay per visit[1]	30% after deductible	$25 copay per visit[1]	30% after deductible	20% after deductible	40% after deductible
Hospital Care	30% after deductible	30% after deductible	$100/admittance	$100/admittance	$100/admittance	30% after deductible	10% after deductible	30% after deductible	10% after deductible	30% after deductible	20% after deductible	40% after deductible
Retail Prescriptions (30-day supply) GenericBrand Non-preferredSpecialty Drugs* *Certain specialty drugs are only available through a retail pharmacy	$10 copay $30 copay Not covered (Prescription copays apply toadeductible)	$10 copay $30 copay Not covered	$10 copay $25 copay Not covered	$10 copay $30 copay $60 copay Covered as non-preferred	$10 copay $30 copay $60 copay Covered as non-preferred	$10 copay $30 copay $60 copay Covered as non-preferred	$10 copay $25 copay $40 copay Covered as non-preferred	25% coinsurance up to $250 per Rx (Retail Rx Only)	$10 copay $25 copay $40 copay Covered under Tier 3 (non-preferred)	25% coinsurance up to $250 per Rx (Retail Rx Only)	$10 copay $30 copay $60 copay 20% up to $100 per Rx	40% coinsurance up to $250 per Rx (Retail Rx Only)
Mail order (100-day supply):	2× copay (after deductible)	2× copay	2× copay	2× copay	2× copay	2× copay	2× copay	Not covered	2× copay	Not covered	2× copay; 20% up to $100 perRx for Specialty	Not Covered
Emergency Room	30% after deductible	30% after deductible	$100 copay per visit (waived if admitted)	$100 copay per visit (waived if admitted)	$100 copay per visit (waived if admitted)	30% after deductible	$100 copay (waived if admitted)		$100 copay (waived if admitted)		20% after deductible	
Ambulance Services	30% after deductible	$150 copay after deductible	No Charge	$50 per trip	$50 per trip	No charge	10%		10%		0%	
Annual Eye Exam	30% after deductible	No Charge	No Charge	No charge	No charge	No Charge	No charge	30%	No charge	30%	No charge	40%
Acupuncture Services	30% after deductible	$40 copay per visit after deductible (must be prescribed)	$25 copay per visit (must be prescribed)	$20 copay per visit	$20 copay per visit	$20 copay per visit	10% after deductible up to 20 visits, in and out ofnetwork combined	10% after deductible up to 20 visits, in and out ofnetwork combined	10% after deductible up to 20 visits, in and out of network combined	10% after deductible up to 20 visits, in and out ofnetwork combined	20% after deductible up to 20 visits, in and out of network combined	40% after deductible up to 20 visits, in and out ofnetwork combined
Chiropractic Services	Not covered	Not covered	Not covered	$20 copay per visit up to 20 visits combined with physical & occupational therapy limit	$20 copay per visit up to 20 visits combined with physical & occupational therapy limit	$20 copay per visit up to 20 visits combined withphysical & occupational therapy limit	10% after deductible up to 20 visits, in and out ofnetwork combined	30% after deductible up to 20 visits, in and out ofnetwork combined	10% after deductible up to 20 visits, in and out of network combined	30% after deductible up to 20 visits, in and out ofnetwork combined	20% after deductible up to 30 visits, in and out of network combined	40% after deductible up to 30 visits, in and out ofnetwork combined
H.S.A. Compatible?	Yes	No	No	No	No	No	No		No		Yes	
Primary Care Physician (PCP) Required?	Yes	Yes	Yes	Yes	Yes	Yes	No		No		No	
Self-Referrals Available?	Consult with Kaiser	Consult with Kaiser	Consult with Kaiser	No	No	No	Yes		Yes		Yes	

[1]Deductible does not apply

This worksheet is intended to be used to help you compare coverage benefits and is a summary ONLY. The Evidence of Coverage (EOC) and the plan contract are the prevailing source for plan details. Effective 1/1/2024