City of San José Office of Retirement Services 2023 Commercial **(Non-Medicare)** Plan Comparison

	Kaiser (California only) $3000 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	$101.36/Month	$243.80/Month	$218.96/Month	$332.84/Month	$44.58/Month	$1631.24/Month		$1782.38/Month		$796.68/Month	
Member+ Spouse/DP	$0.00/Month	$202.70/Month	$487.58/Month	$590.16/Month	$840.70/Month	$206.60/Month	$3697.26/Month		$4029.74/Month		$1861.18/Month	
Member+ Child(ren)	$0.00/Month	$177.38/Month	$426.64//Month	$421.26Month	$626.26/Month	$107.38/Month	$2963.40/Month		$3235.40/Month		$1461.16/Month	
Member+ Spouse/DP+ Child(ren)	$0.00 /Month	$304.06/Month	$731.38/Month	$732.96 /Month	$1086.02 /Month	$192.50/Month	$5111.20/Month		$5379.62 /Month		$2524.00/Month	
Annual Deductible (Calendar Year)	$3,000 Individual $3,000/member $6,000 Family	$1,500 Individual $3,000 Family No Deductible for Primary, Specialistand Preventive visits	None	None	None	$1,500 single $3,000/family	$100 Individual $200 Family	$100 Individual $200 Family	$100 Individual $200 Family	$100 Individual $200 Family	$2,500 single $3,000/member $5,000/family	$2,500 single $3,000/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 $8,000/year	$1,500/year $3,000/year	$1,500/year $3,000/year	$1,500/year $3,000/year	$4,000 single $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 single $4,000/member $8,000 family	$9,000 single $9,000/member $18,000 family
Physician Office Visit	30% coinsurance (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%	$25 copay per visit[1]	30%	20%	40%
Hospital Care	30% coinsurance (after deductible)	30% coinsurance (after deductible)	$100/admittance	$100/admittance	$100/admittance	30%	10%	30%	10%	30%	20%	40%
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 applyafter deductible)	$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% coinsurance (after deductible)	30% coinsurance (after deductible)	$100 copay (waived if admitted)	$100 copay (waived if admitted)	$100 copay (waived if admitted)	30%	$100 copay (waived if admitted)		$100 copay (waived if admitted)		20%	
Ambulance Services	30% coinsurance (after deductible)	$150 copay (after deductible)	No Charge	$50 per trip	$50 per trip	No charge	10%		10%		0%	
Annual Eye Exam	30% coinsurance (after deductible)	No Charge	No Charge	No charge	No charge	No Charge	No charge	30%	No charge	30%	No charge	40%
Acupuncture Services	30% coinsurance (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% up to 20 visits, in and out ofnetwork combined	10% up to 20 visits, in and out ofnetwork combined	10% up to 20 visits, in and out of network combined	10% up to 20 visits, in and out ofnetwork combined	20% up to 20 visits, in and out of network combined	40% 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 withphysical & occupational therapy limit	$20 copay per visit up to 20 visits combined withphysical & occupational therapy limit	10% up to 20 visits, in and out ofnetwork combined	30% up to 20 visits, in and out ofnetwork combined	10% up to 20 visits, in and out of network combined	30% up to 20 visits, in and out ofnetwork combined	20% up to 30 visits, in and out of network combined	40% 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 1/1/2023