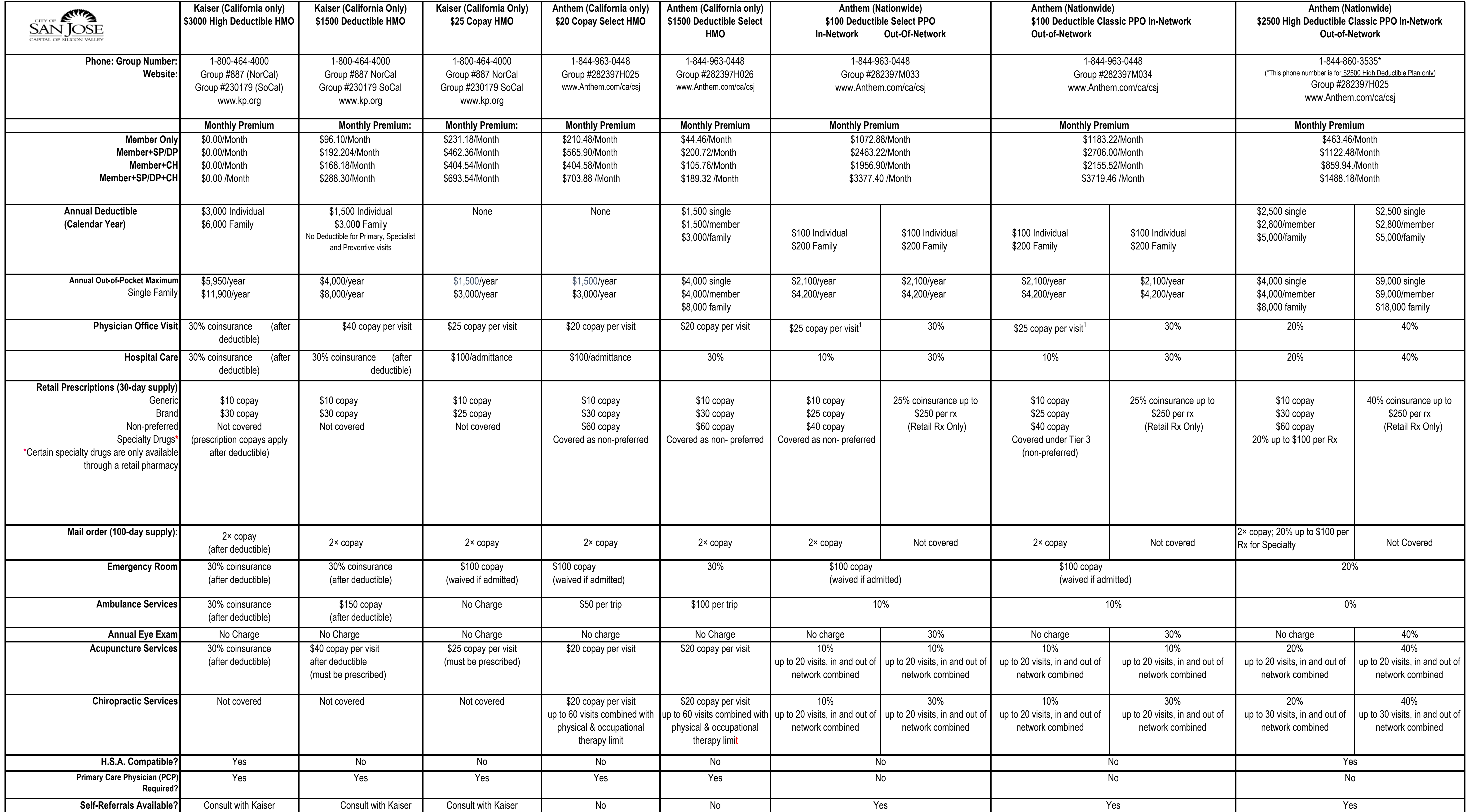
City of San José Office of Retirement Services 2021 **Non-Medicare Plan Comparison**



CITY OF SAN JOSE CAPITAL OF SILICON VALLEY	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) $1500 Deductible Select HMO	Anthem (Nationwide) $100 Deductible Select PPO In-Network	Out-Of-Network	Anthem (Nationwide) $100 Deductible Classic PPO In-Network	Out-of-Network	Anthem (Nationwide) $2500 High Deductible Classic PPO In-Network	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 #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 numbber 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	
Member Only Member+SP/DP Member+CH Member+SP/DP+CH	$0.00/Month $0.00/Month $0.00/Month $0.00 /Month	$96.10/Month $192.204/Month $168.18/Month $288.30/Month	$231.18/Month $462.36/Month $404.54/Month $693.54/Month	$210.48/Month $565.90/Month $404.58/Month $703.88 /Month	$44.46/Month $200.72/Month $105.76/Month $189.32 /Month	$1072.88/Month $2463.22/Month $1956.90/Month $3377.40 /Month		$1183.22/Month $2706.00/Month $2155.52/Month $3719.46 /Month		$463.46/Month $1122.48/Month $859.94./Month $1488.18/Month	
Annual Deductible (Calendar Year)	$3,000 Individual $6,000 Family	$1,500 Individual $3,000 Family No Deductible for Primary, Specialist and Preventive visits	None	None	$1,500 single $1,500/member $3,000/family	$100 Individual $200 Family	$100 Individual $200 Family	$100 Individual $200 Family	$100 Individual $200 Family	$2,500 single $2,800/member $5,000/family	$2,500 single $2,800/member $5,000/family
Annual Out-of-Pocket Maximum Single Family	$5,950/year $11,900/year	$4,000/year $8,000/year	$1,500/year $3,000/year	$1,500/year $3,000/year	$4,000 single $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 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	$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	30%	10%	30%	10%	30%	20%	40%
Retail Prescriptions (30-day supply) Generic Brand Non-preferred Specialty Drugs* *Certain specialty drugs are only available through a retail pharmacy	$10 copay $30 copay Not covered (prescription copays apply after 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 $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	Not covered	2× copay	Not covered	2× copay; 20% up to $100 per Rx for Specialty	Not Covered
Emergency Room	30% coinsurance (after deductible)	30% coinsurance (after deductible)	$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	$100 per trip	10%		10%		0%	
Annual Eye Exam	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	10% up to 20 visits, in and out of network combined	10% up to 20 visits, in and out of network combined	10% up to 20 visits, in and out of network combined	10% up to 20 visits, in and out of network combined	20% up to 20 visits, in and out of network combined	40% up to 20 visits, in and out of network combined
Chiropractic Services	Not covered	Not covered	Not covered	$20 copay per visit up to 60 visits combined with physical & occupational therapy limit	$20 copay per visit up to 60 visits combined with physical & occupational therapy limit	10% up to 20 visits, in and out of network combined	30% up to 20 visits, in and out of network combined	10% up to 20 visits, in and out of network combined	30% up to 20 visits, in and out of network combined	20% up to 30 visits, in and out of network combined	40% up to 30 visits, in and out of network combined
H.S.A. Compatible?	Yes	No	No	No	No	No		No		Yes	
Primary Care Physician (PCP) Required?	Yes	Yes	Yes	Yes	Yes	No		No		No	
Self-Referrals Available?	Consult with Kaiser	Consult with Kaiser	Consult with Kaiser	No	No	Yes		Yes		Yes	

[1]Deductible does not apply