City of San José
Office of Retirement Services
2022 Commercial **(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**
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
	Monthly Premium	**Monthly Premium:**	**Monthly Premium:**
Member Only **Member+ Spouse/Domestic Partner** **Member+ Child(ren)** **Member+ Spouse/Domestic Partner+ Child(ren)**	$1.96/Month $0.00/Month $0.00/Month $0.00 /Month	$97.64/Month $191.36/Month $167.54/Month $287.04/Month	$232.10/Month $460.28/Month $402.74/Month $690.42/Month
Annual Deductible(Calendar Year)	$3,000 Individual $6,000 Family	$1,500 Individual $3,000 Family No Deductible for Primary, Specialistand Preventive visits	None
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
Physician Office Visit	30% coinsurance (after deductible)	$40 copay per visit	$25 copay per visit
Hospital Care	30% coinsurance (after deductible)	30% coinsurance (after deductible)	$100/admittance
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
Mail order (100-day supply):	2× copay (after deductible)	2× copay	2× copay
Emergency Room	30% coinsurance(after deductible)	30% coinsurance(after deductible)	$100 copay (waived if admitted)
Ambulance Services	30% coinsurance(after deductible)	$150 copay (after deductible)	No Charge
Annual Eye Exam	No Charge	No Charge	No Charge
Acupuncture Services	30% coinsurance(after deductible)	$40 copay per visit after deductible (must be prescribed)	$25 copay per visit (must be prescribed)
Chiropractic Services	Not covered	Not covered	Not covered
H.S.A. Compatible?	Yes	No	No
Primary Care Physician (PCP) Required?	Yes	Yes	Yes
Self-Referrals Available?	Consult with Kaiser	Consult with Kaiser	Consult with Kaiser

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CITY OF SAN JOSE CAPITAL OF SILICON VALLEY	Anthem (California only) $20 Copay Traditional HMO ***NEW***	Anthem (California only) $20 Copay Select HMO	Anthem (California only) $1500 Deductible SelectHMO	Anthem (Nationwide) $100 Deductible Select PPO		Anthem (Nationwide) $100 Deductible Classic PPO		Anthem (Nationwide) $2500 High Deductible Classic PPO	
				In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Phone: **Group Number:** **Website:**	1-844-963-0448 Group #282397H025 www.Anthem.com/ca/csj	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 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**	
Member Only **Member+ Spouse/Domestic Partner** **Member+ Child(ren)** **Member+ Spouse/Domestic Partner+ Child(ren)**	$250.50/Month $649.16/Month $472.98/Month $821.64 /Month	$151.54/Month $431.54/Month $294.84/Month $514.84/Month	$0.00/Month $210.34/Month $226.14/Month $45.20/Month	$1378.68/Month $3131.20/Month $2503.86/Month $4319.36 /Month		$1510.08/Month $3420.30/Month $2740.22/Month $4726.40/Month		$653.56/Month $1535.92/Month $1198.48/Month $2071.18/Month	
Annual Deductible(Calendar Year)	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	$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	$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	$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 $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	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	$100 copay (waived if admitted)	$100 copay (waived if admitted)	30%	$100 copay (waived if admitted))		$100 copay (waived if admitted		20%	
Ambulance Services	$50 per trip	$50 per trip	No Charge	10%		10%		0%	
Annual Eye Exam	No charge	No charge	No Charge	No charge	30%	No charge	30%	No charge	40%
Acupuncture Services	$20 copay per visit	$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	$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	$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?	No	No	No	No		No		Yes	
Primary Care Physician (PCP) Required?	Yes	Yes	Yes	No		No		No	
Self-Referrals Available?	No	No	No	Yes		Yes		Yes	

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 Eff/1/1/2022.

[1]Deductible does not apply