2022 medical plan *comparison chart*

	ANTHEM CONSUMER DIRECTED HEALTH PLAN WITH HEALTH SAVINGS ACCOUNT (HSA)		ANTHEM BASE PPO		KAISER PERMANENTE CONSUMER DIRECTED HEALTH PLAN WITH HEALTH SAVINGS ACCOUNT (HSA) (CA and parts of OR and WA)	KAISER PERMANENTE HMO (CA and parts of OR and WA)
	In-network	Out-of-network	In-network	Out-of-network		
Plan features						
LAM RESEARCH CONTRIBUTION TO HSA	$1,300/individual $2,600/family		N/A	N/A	$1,300/individual $2,600/family	N/A
ANNUAL DEDUCTIBLE	$2,000/individual $2,800/individual in family $4,000/family	$4,000/individual $8,000/family	$1,300/individual $2,600/family	$2,600/individual $5,200/family	$2,000/individual $2,800/individual in family $4,000/family	None
	Employees with individual coverage must meet the individual deductible and those with family coverage must meet the family deductible before the plan will begin paying coinsurance for most services (at 85% for in-network/at 70% of the MAA[1] for out-of-network). However, once an individual within a family meets the in-network $2,800 deductible, the plan beings to pay coinsurance for health care costs only for that family member.		The plan pays coinsurance for most services (at 85% of the negotiated rate for in-network/at 70% of the MAA[1] for out-of-network) after one family member or a combination of family members meet the deductible.		Employees with individual coverage must meet the individual deductible and those with family coverage must meet the family deductible before the plan will begin paying benefits. However, once an individual within a family meets the $2,800 deductible, you pay the relevant copays for that family member.	
OUT-OF-POCKET MAXIMUM (INCLUDES DEDUCTIBLE)	$3,000/individual $3,000/individual in family $6,000/family	$6,000/individual $12,000/family	$3,000/individual $6,000/family	$6,000/individual $12,000/family	$3,000/individual $3,000/individual in family $6,000/family	$1,500/individual $3,000/family
Your cost for covered services[1]						
OFFICE VISIT	15% after deductible	30% after deductible	$25 copayment[2]	30% after deductible	$30 after deductible[7]	$20 copayment
SPECIALIST OFFICE VISIT	15% after deductible	30% after deductible	$30 copayment[2]	30% after deductible	$30 after deductible[7]	$20 copayment
WELL CARE FOR ADULTS AND CHILDREN[3]	N/A (no cost to you)	30% after deductible	N/A (no cost to you)	30% after deductible	N/A (no cost to you)	N/A (no cost to you)
EMERGENCY ROOM	15% after deductible	15% after deductible	$150 copayment[2] (waived if admitted)	$150 copayment[2] (waived if admitted)	$100/visit after deductible	$100 copayment (waived if admitted)
INPATIENT HOSPITAL	15% after deductible	30% after deductible	15% after deductible	30% after deductible	$250/admission after deductible	$250 copayment per admission
Your cost for prescription drugs						
PREVENTIVE CARE DRUGS	No cost to you	N/A	You pay the relevant copayment	N/A	No cost to you	You pay the relevant copayment
GENERIC DRUGS	15%[4] after deductible	30% of the covered expense after deductible, plus any amount exceeding the limited fee schedule amount	Retail: $10 copayment[2,4] Mail Order: $20	Retail: $10 copayment plus 50% of covered expense and any balance[5] Mail Order: N/A	$10 after deductible[8]	$10 copayment[9]
PREFERRED DRUGS	15%[4,6] after deductible		Retail: $30 copayment[2,4,6] Mail Order: $60	Retail: $30 copayment plus 50% of covered expense and any balance[5] Mail Order: N/A	$30 after deductible[8] (CA) $20 after deductible[8] (WA & OR)	$20 copayment[9]
NON-PREFERRED DRUGS	15%[4,6] after deductible		Retail: $60 copayment[2,4,6] Mail Order: $120	Retail: $60 copayment plus 50% of covered expense and any balance[5] Mail Order: N/A	N/A	N/A

[1] When you use out-of-network providers, the plan pays benefits up to the maximum allowed amount (MAA). You are responsible for your percentage share of the MAA, plus any amount the provider charges above the MAA.
[2] Your copayments do not count toward the deductible, but they do count toward the out-of-pocket maximum.
[3] Includes immunizations and lab tests (ages 0-6), annual physical exams (age 7 and older), Pap tests, colonoscopies and prostate exams (per age and frequency guidelines).
[4] For mail order prescriptions, CVS/caremark permits a 90-day supply. Your cost is twice the cost of the retail copayment for a 30-day supply. Higher copayments also apply to retail supplies greater than 30 days.
[5] For prescriptions filled at non-network pharmacies, CVS/caremark pays 50% of the fee schedule. You pay the applicable copayment, 50% of the fee schedule, plus any additional charges above the fee schedule.
[6] If a generic drug is available, you pay the difference between the cost of the generic drug and the preferred (or non-preferred) drug, unless your doctor writes the prescription as “dispense as written.”
[7] Exams provided by an optometrist are not subject to the deductible; you pay the copayment only.
[8] For the CDHP, your cost is greater for prescription supplies greater than 30 days.
[9] For the HMO, Kaiser permits prescription supplies of up to 100 days, if authorized by your doctor.

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