2026 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 DEDUCTIBLE HMO (CA and parts of OR and WA)
	In-network	Out-of-network[1]	In-network	Out-of-network[1]		
Plan features						
LAM RESEARCH CONTRIBUTION TO HSA	$1,300/individual $2,600/family		None	None	$1,300/individual $2,600/family	None
ANNUAL DEDUCTIBLE	$2,000/individual $3,400/individual in family $4,000/family	$4,000/individual $8,000/family	$1,300/individual $1,300/individual in family $2,600/family	$2,600/individual $5,200/family	$2,000/individual $3,400/individual in family $4,000/family	$250/individual $250/individual in family $500/family
	Employees with employee-only coverage must meet the individual deductible before the plan will begin paying benefits. If you cover dependents, the plan will begin to pay in-network benefits for a covered individual once that person has met the individual-in-family deductible. Once one or more family members have met the family deductible, the plan will pay benefits for all family members for the rest of the year.					
OUT-OF-POCKET MAXIMUM (INCLUDES DEDUCTIBLE)	$4,000/individual $4,000/individual in family $8,000/family	$8,000/individual $16,000/family	$3,500/individual $3,500/individual in family $7,000/family	$7,000/individual $14,000/family	$4,000/individual $4,000/individual in family $8,000/family	$2,500/individual $2,500/individual in family $5,000/family
Your cost for covered services						
OFFICE VISIT	20% after deductible	50% after deductible	$25 copayment[2]	50% after deductible	20% after deductible[3]	$20 copayment[3]
SPECIALIST OFFICE VISIT	20% after deductible	50% after deductible	$40 copayment[2]	50% after deductible	20% after deductible[4]	$30 copayment
PREVENTIVE CARE FOR ADULTS AND CHILDREN[5]	No cost to you	50% after deductible	No cost to you	50% after deductible	No cost to you	No cost to you
DIAGNOSTIC TEST (E.G., X-RAYS, LABS)	20% after deductible	50% after deductible	20% after deductible	50% after deductible	20% after deductible	$10 after deductible
URGENT CARE	20% after deductible	50% after deductible	$25 copayment[2]	50% after deductible	20% after deductible	CA: $20 after deductible OR & WA: $30 after deductible
EMERGENCY ROOM	20% after deductible	20% after deductible	$150 copayment[2] (waived if admitted)	$150 copayment[2] (waived if admitted)	20% after deductible	CA: $200 after deductible (waived if admitted) OR & WA: $200 with no deductible (waived if admitted)
INPATIENT HOSPITAL	20% after deductible	50% after deductible	20% after deductible	50% after deductible	20% after deductible	20% after deductible

[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 and coinsurance do not count toward the deductible, but they do count toward the out-of-pocket maximum.

[3] Applies to Kaiser members in California and Washington only. For Oregon members: After you meet the deductible, you pay $0 or a $5 copayment for the first three visits of the year (any combination of primary care nonspecialty services, mental health outpatient services, naturopathic medicine visits, substance use disorder outpatient services, and telemedicine services).

[4] Exams provided by an optometrist are not subject to the deductible; you pay the copayment only.

[5] 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).

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	In-network	Out-of-network	In-network	Out-of-network		
Your cost for prescription drugs						
PREVENTIVE CARE DRUGS	No cost to you	Not covered	You pay the relevant copayment	Not covered	No cost to you	You pay the relevant copayment
GENERIC DRUGS	20%[6] after deductible	50% of the covered expense after deductible, plus any amount exceeding the approved fee schedule amount	Retail: $10 copayment[6,7] Mail Order: $20	Retail: $10 copayment plus 50% of covered expense and any balance[9] Mail Order: N/A	$10 after deductible[10]	$10 copayment[11]
PREFERRED DRUGS	20%[6,7] after deductible		Retail: 30% coinsurance up to $100[6,7,8] Mail Order: 30% coinsurance	Retail: 50% coinsurance[9] Mail Order: N/A	$30 after deductible[10]	$30 copayment[11]
NON-PREFERRED DRUGS	20%[6,7] after deductible		Retail: 35% coinsurance up to $150[6,7,8] Mail Order: 35% coinsurance	Retail: 50% coinsurance[9] Mail Order: N/A	CA: Applicable generic or brand copayment applies OR & WA: $60	CA: Applicable generic or brand copayment applies[11] OR & WA: $60[11]
SPECIALTY DRUGS	20%[6,7] after deductible		Retail: $60 copayment[6,7,8] Mail Order: $120	Retail: $60 copayment plus 50% of covered expense and any balance[9] Mail Order: N/A	20% up to $250 after deductible	20% up to $250 after deductible

[6] For mail-order prescriptions, CVS Caremark permits a 90-day supply. Your cost is twice the cost of the retail copayment or coinsurance for a 30-day supply. Higher copayments also apply to retail supplies greater than 30 days.

[7] 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.”

[8] Your copayments and coinsurance do not count toward the deductible, but they do count toward the out-of-pocket maximum.

[9] For prescriptions filled at non-network pharmacies, CVS Caremark pays 50% of an approved fee schedule. You’re responsible for your copayment or coinsurance, 50% of that approved amount, plus any cost above the approved amount.

[10] For the CDHP, your cost is greater for prescription supplies for longer than 30 days.

[11] If authorized by your doctor, Kaiser permits prescription supplies of up to 100 days in California and up to 90 days in Oregon and Washington.