2025/2026 Health Insurance Plans - 12 Month Deductions

Medical		Anthem PPO 40328C	Anthem PPO 40328D	Anthem PPO 40328E	Anthem PPO Proactive Care	WABE (No Medical)	Kaiser Permanente	Kaiser Permanente				
		80/20%	HSA 5000	80/20%	Platinum	WABE	High Plan	Low Plan				
Deductible		\$500/\$1,000	\$5,000	\$2,000/\$4,000	No Deductible	N/A	No Deductible	No Deductible				
Max Out-of-Pocket		\$2,000/\$4,000	\$6,350	\$4,000/\$8,000	\$2,000/\$4,000	N/A	\$1,500/\$3,000	\$1,500/\$3,000				
Medical Co-Insurance		80%	70%	80%	\$0	N/A	\$0	\$0				
PCP/Urgent Care Visit		\$30	\$60 (1st 3 Visits)/30%	\$30	\$0	N/A	\$20	\$30				
Specialist Visit		\$30	30%	\$30	\$70	N/A	\$20	\$30				
X-Ray	20%	20%	30%	20%	\$50	N/A	\$0	\$0				
Other Scans	20%	20%	30%	20%	\$200	N/A	\$0	\$0				
X-Ray	20%	20%	30%	20%	\$150	N/A	\$0	\$0				
Other Scans	20%	20%	30%	20%	\$500	N/A	\$0	\$0				
Independent Laboratory		20%	30%	20%	\$0	N/A	\$0	\$0				
Hospital Laboratory		20%	30%	20%	\$100	N/A	\$0	\$0				
Emergency Room		\$100 + 20%	\$100 + 30%	\$100 + 20%	\$600	N/A	\$100	\$100				
Inpatient Hospital Copay		20%	30%	20%	\$400/day	N/A	\$0	\$0				
Skilled Nursing Services		20%	30%	20%	\$800/day	N/A	\$0	\$0				
Ambulance		\$100 + 20%	\$100 + 30%	\$100 + 20%	\$600	N/A	\$50	\$50				
Generic		\$10	\$9	\$15	\$9	N/A	\$10	\$10				
Brand \$35		\$35	\$35	\$50	\$35	N/A	\$30	\$30				
Employee Pays Per Check												
(le*	\$ 135.74	\$ 81.74	\$-	\$ 32.74	\$ 95.74	\$-	\$ 106.74	\$ 99.24				
rty*	\$ 291.40	\$ 186.40	\$ 25.00	\$ 88.90	\$ 211.40	\$ 25.00	\$ 233.40	\$ 218.40				
ily*	\$ 435.00	\$ 287.50	\$ 50.00	\$ 149.00	\$ 321.00	\$ 50.00	\$ 354.50	\$ 333.50				
nployee elects					Single - \$1.40	2-Party - \$2.80	Family - \$4.20					
Single Medical - 2-Party Dental/Vision			Single Medical - Family	Dental/Vision	\$27.50/Check 2-Party Medical - Family Dental/Vision \$12.50/Check							
	Averance re Visit X-Ray Other Scans X-Ray Other Scans aboratory atory om ital Copay Services Services ital Copay ital Copay	Burance 80% re Visit \$20 X-Ray 20% Other Scans 20% aboratory 20% atory 20% atory 20% Services 20% \$100 + 20% \$200 + 20% \$100 + 20% \$100 + 20% \$100 + 20% \$100 + 20% \$100	PPO PPO 40328B 40328C 80/20% 80/20% 80/20% \$500/\$1,000 \$200/\$500 \$500/\$1,000 \$200/\$500 \$2,000/\$4,000 \$1,000/\$3,000 \$2,000/\$4,000 \$1,000/\$3,000 \$2,000/\$4,000 \$100 * \$20 \$30 \$1 \$20 \$30 \$20 \$30 \$20% \$20% 20% 20% Other Scans 20% 20% A-Ray 20% 20% Other Scans 20% 20% A-Ray 20% 20% A-A 1	PPO PPO PPO PPO 40328B 40328C 40328D 80/20% 80/20% HSA 5000 \$200/\$500 \$500/\$1,000 \$5,000 stance \$1,000/\$3,000 \$2,000/\$4,000 \$6,350 surance 80% 80% 70% re Visit \$20 \$30 \$60 (1st 3 Visits)/30% X-Ray 20% 20% 30% X-Ray 20% 20% 30% X-Ray 20% 20% 30% Other Scans 20% 20% 30% other Scans 20% 20% 30% atory 20% 20% 30% other Scans 20% 20% 30% atory 20% 20% 30% other Scans 20% 20% 30% other Scans 20% 20% 30% atory 20% 20% 30% startory 20% 20% 30%	PPO PPO PPO PPO PPO 40328B 40328C 40328D 40328D 40328E 80/20% 80/20% HSA 5000 80/20% \$200/\$500 \$500/\$1,000 \$5,000 \$2,000/\$4,000 cket \$1,000/\$3,000 \$2,000/\$4,000 \$6,350 \$4,000/\$8,000 urance 80% 80% 70% 80% re Visit \$20 \$30 \$60 (1st 3 Visits)/30% \$30 x-Ray 20% 20% 30% 20% Other Scans 20% <td< td=""><td>PPO PPO PDO PDO<td>PPO 40328B PPO 40328C PPO 40328D PPO 40328D PPO 40328B PPO Proactive Care Proactive Care WABE (No Medical) 80/20% 80/20% HSA 5000 80/20% Platinum WABE \$200/\$500 \$500/\$1,000 \$5,000 \$2,000/\$4,000 No Deductible N/A urance 80% 70% 80% \$2,000/\$4,000 N/A urance 80% 80% 70% 80% \$0 N/A versit \$20 \$30 \$60 (1st 3 Visits)/30% \$30 \$0 N/A versit \$20 \$30 30% \$20% \$0 N/A Versit \$20 \$30 30% \$20% \$0 N/A Versit \$20% 20% 30% 20% \$200 N/A Versit \$20% 20% 30% 20% \$0 N/A Versit \$100 + 20% \$100 + 30% \$100 + 20% \$100 N/A Versi \$100 + 20% \$100 + 30%</td><td>PPO 40328B PPO 40328C PPO 40328D PPO 40328B PPO 40328E PPO Proactive Care (No Medical) WABE (No Medical) Kaiser Permanete 80/20% 80/20% HSA 5000 80/20% Platinum WABE High Plan \$200/\$500 \$500/\$1,000 \$5,000 \$2,000/\$4,000 No Deductible N/A No Deductible \$200/\$3.000 \$2,000/\$4,000 \$6,350 \$4,000/\$8,000 \$2,000/\$4,000 N/A \$1,500/\$3,000 urance 80% 80% 70% 80% \$20 N/A \$1,500/\$3,000 urance 80% 80% 13 visits/30% \$30 \$0 N/A \$20 varace \$200 \$30 \$0(1st 3 visits/30%) \$30 \$70 N/A \$20 X-Ray 20% 20% 30% 20% \$50 N/A \$0 Other Scans 20% 20% 30% 20% \$100 N/A \$0 atory 20% 20% 30% 20% \$100 N/A<!--</td--></td></td></td<>	PPO PDO PDO <td>PPO 40328B PPO 40328C PPO 40328D PPO 40328D PPO 40328B PPO Proactive Care Proactive Care WABE (No Medical) 80/20% 80/20% HSA 5000 80/20% Platinum WABE \$200/\$500 \$500/\$1,000 \$5,000 \$2,000/\$4,000 No Deductible N/A urance 80% 70% 80% \$2,000/\$4,000 N/A urance 80% 80% 70% 80% \$0 N/A versit \$20 \$30 \$60 (1st 3 Visits)/30% \$30 \$0 N/A versit \$20 \$30 30% 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20% \$100 N/A </td				

2025/2026 Health Insurance Plans - 11 Month Deductions

Rates Effective 10/1/2025 - 9/30/2026

Medical		Anthem PPO 40328B 80/20%	Anthem PPO 40328C 80/20%	Anthem PPO 40328D HSA 5000	Anthem PPO 40328E 80/20%	Anthem PPO Proactive Care Platinum	WABE (No Medical) WABE	Kaiser Permanente High Plan	Kaiser Permanente Low Plan			
Deductible		\$200/\$500	\$500/\$1,000	\$5,000	\$2,000/\$4,000	No Deductible	N/A	No Deductible	No Deductible			
Max Out-of-Pocket		\$1,000/\$3,000	\$2,000/\$4,000	\$6,350	\$4,000/\$8,000	\$2,000/\$4,000	N/A	\$1,500/\$3,000	\$1,500/\$3,000			
Medical Co-Insurance		80%	80%	70%	80%	\$0	N/A	\$0	\$0			
PCP/Urgent Care Visit		\$20	\$30	\$60 (1st 3 Visits)/30%	\$30	\$0	N/A	\$20	\$30			
Specialist Visit		\$20	\$30	30%	\$30	\$70	N/A	\$20	\$30			
Padialogy Contor	X-Ray	20%	20%	30%	20%	\$50	N/A	\$0	\$0			
Radiology Center	Other Scans	20%	20%	30%	20%	\$200	N/A	\$0	\$0			
Outpatient Heepital	X-Ray	20%	20%	30%	20%	\$150	N/A	\$0	\$0			
Outpatient Hospital	Other Scans	20%	20%	30%	20%	\$500	N/A	\$0	\$0			
Independent Laboratory		20%	20%	30%	20%	\$0	N/A	\$0	\$0			
Hospital Laboratory		20%	20%	30%	20%	\$100	N/A	\$0	\$0			
Emergency Room		\$100 + 20%	\$100 + 20%	\$100 + 30%	\$100 + 20%	\$600	N/A	\$100	\$100			
Inpatient Hospital Copay		20%	20%	30%	20%	\$400/day	N/A	\$0	\$0			
Skilled Nursing Services		20%	20%	30%	20%	\$800/day	N/A	\$0	\$0			
Ambulance		\$100 + 20%	\$100 + 20%	\$100 + 30%	\$100 + 20%	\$600	N/A	\$50	\$50			
Prescription												
Generic		\$9	\$10	\$9	\$15	\$9	N/A	\$10	\$10			
Brand		\$35	\$35	\$35	\$50	\$35	N/A	\$30	\$30			
Employee Pays Per Check												
Single		\$ 148.08	\$ 89.17	\$-	\$ 35.72	\$ 104.44	\$ -	\$ 116.44	\$ 108.26			
2-Party		\$ 317.89	\$ 203.35	\$ 27.27	\$ 96.98	\$ 230.62	-	\$ 254.62	\$ 238.25			
Family		\$ 474.55	\$ 313.64	\$ 54.55	\$ 162.55	\$ 350.18	\$ 54.55	\$ 386.73	\$ 363.82			
*If Emplo	sion Plan XP Hea	lth, additional c	ost applies each pay pe	riod	Single - \$1.53	2-Party - \$3.06	Family - \$4.58					
Single Medical - 2-Party Dental/Vision			\$13.63/Check Single Medical - Family Dental/Vision			\$30.00/Check 2-Party Medical - Family Dental/Vision \$13.63/Check						