

Medical - Washington

2026 Medical Plan Comparison

	Anthem High Deductible PPO		Kaiser WA HMO
	In Network	Out of Network*	Kaiser WA providers only. No out-of-network coverage.
Preventive Care	100%, no deductible	60% covered after deductible	100%
Deductible	\$3,400 per person \$6,800 per family		No deductible
Out-of-Pocket Maximum	\$4,500 per person \$9,000 per family	\$8,000 per person \$16,000 per family	\$1,000 per person \$2,000 per family
Primary Care Physician	80% covered after deductible	60% covered after deductible	\$15 copay per visit
Specialist	80% covered after deductible	60% covered after deductible	\$15 copay per visit
Telehealth	\$0 through LiveHealth Online	60% covered after deductible	\$0 copay
Emergency Room	80% of eligible charges covered after deductible		\$200 copay (waived if admitted)**
Urgent Care	80% covered after deductible	60% covered after deductible	\$15 copay
Hospital Stay	80% covered after deductible	60% covered after deductible	100% covered
Eligible Health Care Spending Accounts	Health Savings Account (HSA) and Health Flexible Spending Account (HFSA)		Health Flexible Spending Account (HFSA)

*Out-of-network providers may bill members for the difference between the provider's full charges and the amount paid by the plan.
 **If out of network, notify Kaiser within 24 hours; out-of-network follow-up care is not covered.

Monthly Employee Premiums

	Employee Only	Employee + Child(ren)	Employee + Spouse	Employee + Family
Anthem High Deductible PPO	\$74	\$155	\$177	\$278
Kaiser WA HMO	\$170	\$359	\$414	\$643



Prescriptions - Washington

	Anthem High Deductible PPO		Kaiser WA HMO
	Retail Pharmacy		
	In Network Participating Providers (Up to 30-Day Supply)	Out of Network* Non-Participating Providers (Up to 30-Day Supply)	Participating Providers (Up to 30-Day Supply)
Preventive	<i>Deductible waived</i>	<i>Deductible applies</i>	<i>No deductible</i>
Generic	\$15 copay	60% after deductible	\$10 copay
Brand-name formulary	\$45 copay	60% after deductible	\$40 copay
Brand-name non-formulary	\$75 copay	60% after deductible	
Non-Preventive	<i>Deductible applies</i>	<i>Deductible applies</i>	<i>No deductible</i>
Generic	20% coinsurance up to \$100 per prescription, after deductible	60% after deductible	\$10 copay
Brand-name formulary	20% coinsurance up to \$250 per prescription, after deductible	60% after deductible	\$40 copay
Brand-name non-formulary	20% coinsurance up to \$250 per prescription, after deductible	60% after deductible	

*Out-of-network providers may bill members for the difference between the provider's full charges and the amount paid by the plan.



Prescriptions - Washington

	Anthem High Deductible PPO		Kaiser WA HMO
Mail Order			
	In Network Participating Providers (Up to 90-Day Supply)	Out of Network Non-Participating Providers (Up to 90-Day Supply)	Participating Providers (Up to 90-Day Supply)
Preventive	<i>Deductible waived</i>	<i>Deductible applies</i>	<i>No deductible</i>
Generic	\$30 copay	Not covered	\$20 copay
Brand-name formulary	\$90 copay	Not covered	\$80 copay
Brand-name non-formulary	\$150 copay	Not covered	
Non-Preventive	<i>Deductible applies</i>	<i>Deductible applies</i>	<i>No deductible</i>
Generic	20% coinsurance up to \$200 per prescription, after deductible	Not covered	\$20 copay
Brand-name formulary	20% coinsurance up to \$500 per prescription, after deductible	Not covered	\$80 copay
Brand-name non-formulary	20% coinsurance up to \$500 per prescription, after deductible	Not covered	
Specialty Pharmacy			
	Participating Providers (Up to 30-Day Supply)	Non-Participating Providers	Participating Providers (Up to 30-Day Supply)
Specialty	\$75 copay	Not covered	Not covered

Medical - Owens Valley

2026 Medical Plan Comparison

	Anthem High Deductible PPO		Anthem Owens Valley PPO
	In Network	Out of Network*	Anthem Owens Valley providers only. No out-of-network coverage.*
Preventive Care	100%, no deductible	60% covered after deductible	100%
Deductible	\$3,400 per person \$6,800 per family		No deductible
Out-of-Pocket Maximum	\$4,500 per person \$9,000 per family	\$8,000 per person \$16,000 per family	N/A
Primary Care Physician	80% covered after deductible	60% covered after deductible	\$15 copay per visit
Specialist	80% covered after deductible	60% covered after deductible	\$15 copay per visit
Telehealth	\$0 through LiveHealth Online	60% covered after deductible	\$0 through LiveHealth Online
Emergency Room	80% of eligible charges covered after deductible		\$250 copay (waived if admitted), then 100% covered
Urgent Care	80% covered after deductible	60% covered after deductible	\$15 copay per visit
Hospital Stay	80% covered after deductible	60% covered after deductible	\$250 copay per admission, then 100% covered**
Eligible Health Care Spending Accounts	Health Savings Account (HSA) and Health Flexible Spending Account (HFSA)		Health Flexible Spending Account (HFSA)

*Out-of-network providers may bill members for the difference between the provider's full charges and the amount paid by the plan.
 **Additional \$500 deductible applies if you do not receive preauthorization for a non-emergency hospital admission.

Monthly Employee Premiums

	Employee Only	Employee + Child(ren)	Employee + Spouse	Employee + Family
Anthem High Deductible PPO	\$74	\$155	\$177	\$278
Anthem Owens Valley	\$170	\$359	\$414	\$643



Prescriptions - Owens Valley

	Anthem High Deductible PPO		Anthem Owens Valley PPO
	Retail Pharmacy		
	In Network Participating Providers (Up to 30-Day Supply)	Out of Network* Non-Participating Providers (Up to 30-Day Supply)	Participating Providers (Up to 30-Day Supply)
Preventive	<i>Deductible waived</i>	<i>Deductible applies</i>	<i>No deductible</i>
Generic	\$15 copay	60% after deductible	\$15 copay
Brand-name formulary	\$45 copay	60% after deductible	\$45 copay
Brand-name non-formulary	\$75 copay	60% after deductible	\$75 copay
Non-Preventive	<i>Deductible applies</i>	<i>Deductible applies</i>	<i>No deductible</i>
Generic	20% coinsurance up to \$100 per prescription, after deductible	60% after deductible	\$15 copay
Brand-name formulary	20% coinsurance up to \$250 per prescription, after deductible	60% after deductible	\$45 copay
Brand-name non-formulary	20% coinsurance up to \$250 per prescription, after deductible	60% after deductible	\$75 copay

*Out-of-network providers may bill members for the difference between the provider's full charges and the amount paid by the plan.



Prescriptions - Owens Valley

	Anthem High Deductible PPO		Anthem Owens Valley PPO
	Mail Order		
	In Network Participating Providers (Up to 90-Day Supply)	Out of Network Non-Participating Providers (Up to 90-Day Supply)	Participating Providers (Up to 90-Day Supply)
Preventive	<i>Deductible waived</i>	<i>Deductible applies</i>	<i>No deductible</i>
Generic	\$30 copay	Not covered	\$30 copay
Brand-name formulary	\$90 copay	Not covered	\$90 copay
Brand-name non-formulary	\$150 copay	Not covered	\$150 copay
Non-Preventive	<i>Deductible applies</i>	<i>Deductible applies</i>	<i>No deductible</i>
Generic	20% coinsurance up to \$200 per prescription, after deductible	Not covered	\$30 copay
Brand-name formulary	20% coinsurance up to \$500 per prescription, after deductible	Not covered	\$90 copay
Brand-name non-formulary	20% coinsurance up to \$500 per prescription, after deductible	Not covered	\$150 copay
	Specialty Pharmacy		
	In Network Participating Providers (Up to 30-Day Supply)	Non-Participating Providers	Participating Providers (Up to 30-Day Supply)
Specialty	\$75 copay	Not covered	Not covered

Medical - Other Locations

2026 Medical Plan Comparison

	Anthem High Deductible PPO		Anthem BlueCard PPO	
	In Network	Out of Network*	In Network	Out of Network*
Preventive Care	100%, no deductible	60% covered after deductible	100%, no deductible	20% coinsurance
Deductible	\$3,400 per person \$6,800 per family		\$250 per person \$750 family	\$750 per person \$2,250 per family
Out-of-Pocket Maximum	\$4,500 per person \$9,000 per family	\$8,000 per person \$16,000 per family	\$1,500 per person \$3,000 per family	\$2,000 per person \$4,000 per family
Primary Care Physician	80% covered after deductible	60% covered after deductible	\$20 copay per visit (deductible does not apply)	20% coinsurance
Specialist	80% covered after deductible	60% covered after deductible	\$20 copay per visit (deductible does not apply)	20% coinsurance
Telehealth	\$0 through LiveHealth Online	60% covered after deductible	\$0 through LiveHealth Online	20% coinsurance
Emergency Room	80% of eligible charges covered after deductible		\$250 copay (waived if admitted) and then 0% coinsurance for facility, doctor and other services	Covered as in network
Urgent Care	80% covered after deductible	60% covered after deductible	\$20 copay per visit (deductible does not apply)	20% coinsurance
Hospital Stay	80% covered after deductible	60% covered after deductible	0% coinsurance with \$250 deductible for facility fees**	20% coinsurance
Eligible Health Care Spending Accounts	Health Savings Account (HSA) and Health Flexible Spending Account (HFSA)		Health Flexible Spending Account (HFSA)	

*Out-of-network providers may bill members for the difference between the provider's full charges and the amount paid by the plan.

**Additional \$500 deductible applies if you do not receive preauthorization for a non-emergency hospital admission.

Monthly Employee Premiums

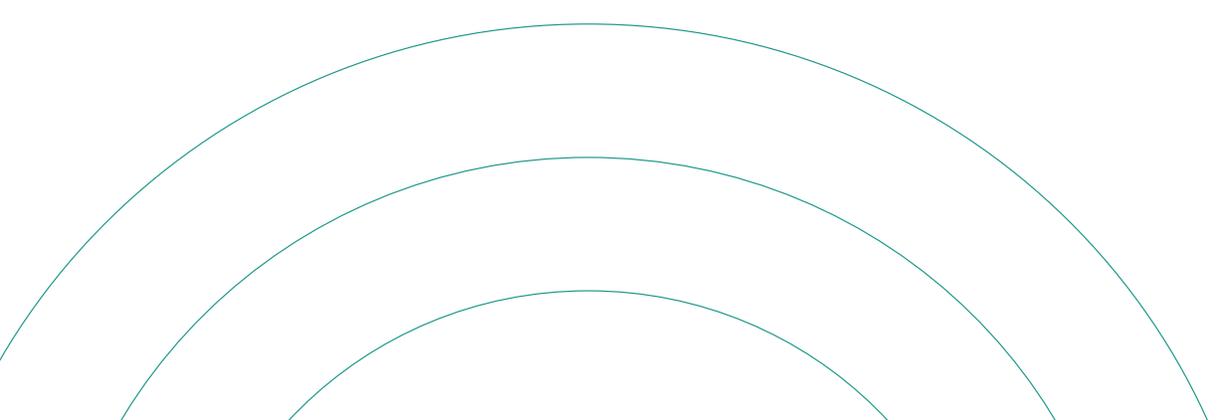
	Employee Only	Employee + Child(ren)	Employee + Spouse	Employee + Family
Anthem High Deductible PPO	\$74	\$155	\$177	\$278
Anthem BlueCard PPO	\$170	\$359	\$414	\$643



Prescriptions - Other Locations

	Anthem High Deductible PPO		Anthem BlueCard PPO	
	Retail Pharmacy			
	In Network Participating Providers (Up to 30-Day Supply)	Out of Network* Non-Participating Providers (Up to 30-Day Supply)	In Network Participating Providers (Up to 30-Day Supply)	Out of Network Non-Participating Providers (Up to 30-Day Supply)*
Preventive	<i>Deductible waived</i>	<i>Deductible applies</i>	<i>No deductible</i>	<i>No deductible</i>
Generic	\$15 copay	60% after deductible	\$15 copay	50% after \$15 copay
Brand-name formulary	\$45 copay	60% after deductible	\$45 copay	50% after \$45 copay
Brand-name non-formulary	\$75 copay	60% after deductible	\$75 copay	50% after \$150 copay
Non-Preventive	<i>Deductible applies</i>	<i>Deductible applies</i>	<i>No deductible</i>	<i>No deductible</i>
Generic	20% coinsurance up to \$100 per prescription, after deductible	60% after deductible	\$15 copay	50% after \$15 copay
Brand-name formulary	20% coinsurance up to \$250 per prescription, after deductible	60% after deductible	\$45 copay	50% after \$45 copay
Brand-name non-formulary	20% coinsurance up to \$250 per prescription, after deductible	60% after deductible	\$75 copay	50% after \$150 copay

*Out-of-network providers may bill members for the difference between the provider's full charges and the amount paid by the plan.



Prescriptions - Other Locations

	Anthem High Deductible PPO		Anthem BlueCard PPO	
	Mail Order			
	In Network Participating Providers (Up to 90-Day Supply)	Out of Network Non-Participating Providers (Up to 90-Day Supply)	In Network Participating Providers (Up to 90-Day Supply)	Out of Network Non-Participating Providers (Up to 90-Day Supply)
Preventive	<i>Deductible waived</i>		<i>No deductible</i>	
Generic	\$30 copay	Not covered	\$30 copay	Not covered
Brand-name formulary	\$90 copay	Not covered	\$90 copay	Not covered
Brand-name non-formulary	\$150 copay	Not covered	\$150 copay	Not covered
Non-Preventive	<i>Deductible applies</i>		<i>No deductible</i>	
Generic	20% coinsurance up to \$200 per prescription, after deductible	Not covered	\$30 copay	Not covered
Brand-name formulary	20% coinsurance up to \$500 per prescription, after deductible	Not covered	\$90 copay	Not covered
Brand-name non-formulary	20% coinsurance up to \$500 per prescription, after deductible	Not covered	\$150 copay	Not covered
	Specialty Pharmacy			
	Participating Providers (Up to 30-Day Supply)	Non-Participating Providers	Participating Providers (Up to 30-Day Supply)	Non-Participating Providers
Specialty	\$75 copay	Not covered	\$75 copay	Not covered

Hawaii

2026 Medical Plan

	Hawaii Medical Service Association
Preventive Care	100%
Deductible	No deductible
Out-of-Pocket Maximum	\$2,500 per person \$7,500 per family
Primary Care Physician	\$14 copay per visit
Specialist	\$14 copay per visit
Emergency Room	Facility: 20% coinsurance Provider: \$20 copay
Urgent Care	\$14 copay per visit
Hospital Stay	Facility: 20% coinsurance Provider: \$20 copay
Eligible Health Care Spending Accounts	Health Flexible Spending Account (HFSA)

Monthly Employee Premiums

HMSA: CompMED Choice Med w/RX & Vision

Employee Only	\$0
Employee + Child(ren)	\$414 EE + Child \$643 EE + Children
Employee + Spouse	\$414
Employee + Family	\$643

Prescriptions

	Hawaii Medical Service Association	
	Retail Pharmacy	
	Participating Providers (Up to 30-Day Supply)	Non-Participating Providers (Up to 30-Day Supply)
Generic	\$7 copay	20% after \$7 copay
Brand-name formulary	\$30 copay	20% after \$30 copay
Brand-name non-formulary	\$30 copay*	20% after \$30 copay*

	Mail Order	
	Participating Providers (Up to 90-Day Supply)	Non-Participating Providers
Generic	\$11 copay	Not covered
Brand-name formulary	\$65 copay	Not covered
Brand-name non-formulary	\$65 copay*	Not covered

	Specialty Pharmacy	
	Participating Providers (Up to 30-Day Supply)	Non-Participating Providers
Specialty	\$100 copay	Not covered
Non-preferred Specialty	\$200 copay	Not covered