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Major Medical Comparison Chart

MAJOR MEDICAL PLANS	**Anthem PPO** CoreChoice $4,000 Deductible Bronze Plan **Option 1**	**Anthem PPO** CoreChoice $3,000 Deductible Base Plan **Option 2**	**Anthem PPO** CoreChoice $0 Deductible Bronze Plan **Option 3**	**Anthem PPO** CoreChoice $6,000 Deductible HSA Plan **Option 4**
	IN-NETWORK BENEFITS			
Network	Anthem BlueCard	Anthem BlueCard	Anthem BlueCard	Anthem BlueCard
Lifetime Maximum	Unlimited	Unlimited	Unlimited	Unlimited
Deductible Type Individual Family **Co-insurance**	 Calendar Year $4,000 $10,000 20%	 Calendar Year $3,000 $6,000 50%	 Calendar Year $0 $0 40%	 Calendar Year $6,000 $12,000 30%
Out of Pocket Maximum Individual Family	 $9.100 $18,200	 $5,350 $10,700	 $7,350 $14,700	 $8,300 $16,600
Physician Office Visit Preventive Care Office Visit - Primary Office Visit - Specialist Lab / X-ray Complex Imaging (CT, MRI, PET Scans) Outpatient Mental Health Inpatient Mental Health	 100% covered $45 copay $45 copay $30 copay / 20% after deductible 20% after deductible $45 copay 20% after deductible	 100% covered 50% after deductible 50% after deductible 50% after deductible 50% after deductible Not covered Not covered	 100% covered 40% co-insurance 40% co-insurance 40% co-insurance 40% co-insurance 40% co-insurance 40% co-insurance	 100% covered 30% after deductible 30% after deductible 30% after deductible 30% after deductible Not covered Not covered
Hospital Services Inpatient Surgery Outpatient Surgery Emergency Room Urgent Care	 20% after deductible 20% after deductible $350 copay $45 copay	 50% after deductible 50% after deductible 50% after deductible 50% after deductible	 40% co-insurance 40% co-insurance 40% co-insurance 40% co-insurance	 30% after deductible 30% after deductible 30% after deductible 30% after deductible
Prescription Drug Coverage Deductible **Retail | Mail-Order** Tier 1 Tier 2 Tier 3 Tier 4	 None $10 copay $25 copay $50 copay $87 copay $75 copay $175 copay Not Covered Not Covered	 None $10 copay $25 copay $35 copay $87.50 copay $70 copay $175 copay Not Covered Not Covered	 None 40% co-insurance 40% co-insurance 40% co-insurance 40% co-insurance 40% co-insurance 40% co-insurance Not Covered Not Covered	 $2,500 / $5,000 Copays After Deductible Met $10 copay $25 copay $35 copay $87.50 copay $70 copay $175 copay Not Covered Not Covered
	OUT-OF-NETWORK BENEFITS			
Deductible Individual Family **Co-insurance**	 $5,000 $15,000 50%	 Not Covered Not Covered N/A	 Not Covered Not Covered N/A	 Not Covered Not Covered N/A
Out-of-Pocket Maximum Individual Family	 $13,500 $36,000	 Not Covered Not Covered	 Not Covered Not Covered	 Not Covered Not Covered
	SEMI MONTLY RATES*			
Employee Only	$581.90	$508.20	$590.70	$500.50
Employee + Spouse	$1,138.50	$941.60	$1,096.70	$932.80
Employee + Single Child	$864.60	$800.80	$948.20	$770.00
Employee + Children / Family	$1,321.65	$1,173.15	$1,320.55	$1,174.25

MAJOR MEDICAL PLANS	UHC PPO UHC $8,000 Deductible Bronze Plan Option 5	UHC PPO UHC $5,000 Deductible Silver Plan Option 6	UHC PPO UHC $3,000 Deductible Gold Plan Option 7	UHC PPO UHC $2,000 Deductible Gold Plan Option 8
	IN-NETWORK BENEFITS			
Network	UHC Choice Plus	UHC Choice Plus	UHC Choice Plus	UHC Choice Plus
Lifetime Maximum	Unlimited	Unlimited	Unlimited	Unlimited
Deductible Type Individual Family **Co-insurance**	Calendar Year $8,000 $16,000 0%	Calendar Year $5,000 $10,000 20%	Calendar Year $3,000 $6,000 20%	Calendar Year $2,000 $4,000 20%
Out of Pocket Maximum Individual Family	$10,000 $20,000	$8,000 $16,000	$5,000 $10,000	$6,500 $13,500
Physician Office Visit Preventive Care Office Visit - Primary Office Visit - Specialist Lab / X-ray Complex Imaging (CT, MRI, PET Scans) Outpatient Mental Health Inpatient Mental Health	100% covered $25 copay $50 copay No charge No charge after deductible $25 copay No charge after deductible	100% covered $25 copay $50 copay No charge 20% after deductible $25 copay 20% after deductible	100% covered $25 copay $50 copay No charge 20% after deductible $25 copay 20% after deductible	100% covered $25 copay $50 copay No charge 20% after deductible $25 copay 20% after deductible
Hospital Services Inpatient Surgery Outpatient Surgery Emergency Room Urgent Care	No charge after deductible No charge after deductible $500 copay $50 copay	20% after deductible 20% after deductible $500 copay, 20% co-insurance $50 copay	20% after deductible 20% after deductible $500 copay, 20% co-insurance $50 copay	20% after deductible 20% after deductible $500 copay, 20% co-insurance $50 copay
Prescription Drug Coverage Deductible **Retail | Mail-Order** Tier 1 Tier 2 Tier 3 Tier 4	None $10 copay $25 copay $40 copay $100 copay $85 copay $212.50 copay $250 copay $625 copay	None $10 copay $25 copay $40 copay $100 copay $85 copay $212.50 copay $250 copay $625 copay	None $10 copay $25 copay $40 copay $100 copay $85 copay $212.50 copay $250 copay $625 copay	None $10 copay $25 copay $40 copay $100 copay $85 copay $212.50 copay $250 copay $625 copay
	OUT-OF-NETWORK BENEFITS			
Deductible Individual Family **Co-insurance**	$8,000 $16,000 30%	$10,000 $20,000 50%	$10,000 $20,000 50%	$10,000 $20,000 50%
Out-of-Pocket Maximum Individual Family	$10,000 $20,000	$25,000 $50,000	$25,000 $50,000	$25,000 $50,000
	SEMI MONTLY RATES*			
Employee Only	$773.30	$764.50	$821.15	$806.85
Employee + Spouse	$1,644.00	$1,625.00	$1,750.00	$1,718.00
Employee + Child(ren)	$1,285.35	$1,269.40	$1,372.25	$1,345.85
Employee + Family	$2,167.00	$2,140.50	$2,313.00	$2,268.50

MAJOR MEDICAL PLANS	UHC PPO UHC $8,000 Deductible HSA Plan Option 9	UHC PPO UHC $6,750 Deductible HSA Plan Option 10
	IN-NETWORK BENEFITS	
Network	UHC Choice Plus	UHC Choice Plus
Lifetime Maximum	Unlimited	Unlimited
Deductible Type Individual Family **Co-insurance**	 Calendar Year $8,000 $16,000 20%	 Calendar Year $6,750 $13,500 20%
Out of Pocket Maximum Individual Family	 $8,300 $16,600	 $8,300 $16,600
Physician Office Visit Preventive Care Office Visit - Primary Office Visit - Specialist Lab / X-ray Complex Imaging (CT, MRI, PET Scans) Outpatient Mental Health Inpatient Mental Health	 100% covered 20% after deductible 20% after deductible 20% after deductible 20% after deductible 20% after deductible 20% after deductible	 100% covered 20% after deductible 20% after deductible 20% after deductible 20% after deductible 20% after deductible 20% after deductible
Hospital Services Inpatient Surgery Outpatient Surgery Emergency Room Urgent Care	 20% after deductible 20% after deductible No charge after deductible 20% after deductible	 20% after deductible 20% after deductible No charge after deductible 20% after deductible
Prescription Drug Coverage Deductible **Retail | Mail-Order** Tier 1 Tier 2 Tier 3 Tier 4	 Prescriptions Subject to Plan Deductible No charge No charge No charge No charge No charge No charge No charge No charge	 None No charge No charge No charge No charge No charge No charge No charge No charge
	OUT-OF-NETWORK BENEFITS	
Deductible Individual Family **Co-insurance**	 $10,000 $20,000 30%	 $10,000 $20,000 30%
Out-of-Pocket Maximum Individual Family	 $20,000 $40,000	 $20,000 $40,000
	SEMI MONTLY RATES*	
Employee Only	$570.90	$595.10
Employee + Spouse	$1,183.60	$1,239.70
Employee + Child(ren)	$920.70	$962.50
Employee + Family	$1,557.50	$1,627.50

MINIMUM VALUE PLANS	First Health PPO Copay Gold Plan **Option 11**	First Health PPO Copay Silver Plan **Option 12**	First Health PPO Copay Bronze Plan **Option 13**
	PLAN BENEFITS		
Network	First Health Network	First Health Network	First Health Network
Lifetime Maximum	Unlimited	Unlimited	Unlimited
Deductible Type Individual Family	 Calendar Year $0 $0	 Calendar Year $0 $0	 Calendar Year $0 $0
Out of Pocket Maximum*** Individual Family	 $6,000 $12,000	 $7,000 $14,000	 $8,000 $16,000
Physician Office Visit Preventive Care Office Visit - Primary* Office Visit - Specialist* Telehealth Lab / X-ray* Complex Imaging (CT, MRI, PET Scans)* Outpatient Mental Health* Inpatient Therapy *	 100% covered $25 copay $35 copay $0 copay $35 copay $375 copay $35 copay $750 copay	 100% covered $35 copay $50 copay $0 copay $50 copay $500 copay $50 copay $1,000 copay	 100% covered $50 copay $75 copay $0 copay $75 copay $750 copay $75 copay $1,500 copay
Hospital Services Inpatient Facility* Inpatient Surgery* Outpatient Office Visit* Outpatient Surgery* Emergency Room* Urgent Care	 $750 copay $375 copay $50 copay $375 copay $375 copay $35 copay	 $1,000 copay $500 copay $70 copay $500 copay $500 copay $50 copay	 $1,500 copay $750 copay $100 copay $750 copay $750 copay $75 copay
Prescription Drug Coverage Deductible **Retail | Mail-Order** Tier 1 Tier 2 Tier 3 Tier 4	$500 $0 copay 20% co-insurance 20% co-insurance Not Covered $0 copay 20% co-insurance 20% co-insurance Not Covered	$250 $0 copay 30% co-insurance 30% co-insurance Not Covered $0 copay 30% co-insurance 30% co-insurance Not Covered	$500 $0 copay 40% co-insurance 40% co-insurance Not Covered $0 copay 40% co-insurance 40% co-insurance Not Covered
	MINIMUM VALUE PLAN DETAILS		
Items with *	Plan coverages subject to visit and procedure limits per calendar year. For full coverage details, refer to plan brochure.		
Prescription Drug Coverage**	Prescription drugs regardless of tier will be limited to a $500 per month benefit for any 30-day fill and $1,500 for a 90-day supply.		
Out of Pocket Maximum *	Coverage is subject to plan limits and allowable claim amounts. Services not covered or exceeding plan limits may still be your responsibility.		
	SEMI MONTLY RATES*		
Employee Only	$438.38	$373.00	$307.30
Employee + Spouse	$690.42	$571.02	$454.06
Employee + Child(ren)	$652.74	$571.05	$432.42
Employee + Family	$862.26	$713.93	$561.78

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*All pricing are semi-monthly rates, effective for 2026. Includes all applicable taxes and fees.
Each plan comes with advocacy services and 401k administration.

Anthem Major Medical plans are underwritten by Amalgamated Local 426 S.W. Workers Union, and not Anthem BCBS.

UHC Major Medical plans are underwritten by UnitedHealthcare.

Minimum Value plans are underwritten by Magna Insurance Company, and not First Health.