2026 NSCA Medical Plans

* Amounts reflect employee cost

Plan Name	Anthem HSA Plan		Anthem PPO Plan		Kaiser-Northern and Southern Califirnia	Kaiser Hawaii
Network Identifier	**In Network**	**Out of Network**	**In Network**	**Out of Network**	**In Netowrk Only**	**In Netowrk Only**
Accumulation Method (Ded)	Aggregate		Embedded		Aggregate	Embedded
Deductible - Single	$1,800	$3,600	$700	$2,000	$0	$0
Deductible - Family	$3,600	$7,200	$1,400	$4,000	$0	$0
Annual Company Contribution-Single/Family (bi-weekly contr.)	$250 / $500		n/a		n/a	n/a
Wellness Incentives	Up to $500		Up to $500			
General Coinsurance	0% after deductible *	40% after deductible *	20% after deductible *	40% after deductible *	20% after dedutible	Varies depending on service
Accumulation Method (OOP)	Embedded		Embedded			
Max OOP - Single	$6,000	$10,000	$3,000	$7,000	$1,500	$2,500
Max OOP - Family	$12,000	$20,000	$6,000	$14,000	$3,000	$7,500
Preventive Services	$0	$0	$0	40% after deductible	$0	$0
Office Visit – Primary Care	0% after deductible	40% after deductible	$30 copay	40% after deductible	$35 copay	$15
Office Visit - Specialty	0% after deductible	40% after deductible	$60 copay	40% after deductible	$35 copay	$15
Urgent Care	0% after deductible	40% after deductible	$75 copay	40% after deductible	$35 per visit	$15
Emergency Room	Deductible then $500 copay		$500 copay		$100	$100
Inpatient Hospital	0% after deductible	40% after deductible	20% after deductible	40% after deductible	$500 per admission	10% coinsurance
Lab work	0% after deductible	40% after deductible	20% after deductible	40% after deductible	No charge	$15
X-rays	0% after deductible	40% after deductible	20% after deductible	40% after deductible	No charge	$15
Pharmacy						
Rx Deductible - Single	Combined with medical	Not Covered	No Deductible	Not Covered		
Rx Deductible - Family	Combined with medical	Not Covered	No Deductible	Not Covered		
Generic	$10	Not Covered	$10	Not Covered	$15	$10
Formulary	$30	Not Covered	$30	Not Covered	$35	$45
Non-Formulary	$60	Not Covered	$60	Not Covered	$35	$45
Mail Order - Generic	$20	Not Covered	$20	Not Covered	$30	$20
Mail Order - Formulary	$60	Not Covered	$60	Not Covered	$70	$90
Mail Order - Non- Formulary	$120	Not Covered	$120	Not Covered	$70	$90