

AFFORDABLE CARE ACT COVERAGE

Name: _____

Employee ID# : _____

Coverage Start Date: _____

Employee Type: _____

Rates as of 10/1/2025:

Medical Plan	Check one	Coverage Election	Monthly Premium	Employer Cost	Employee Cost
Kaiser Permanente HMO	<input type="checkbox"/>	Single	\$ 982.00	\$ 864.36	\$ 117.64
	<input type="checkbox"/>	Double	\$2,052.00	\$ 0.00	\$2,052.00
	<input type="checkbox"/>	Family	\$2,850.00	\$ 0.00	\$2,850.00
Kaiser ABHP/HSA	<input type="checkbox"/>	Single	\$ 783.00	\$ 665.36	\$ 117.64
	<input type="checkbox"/>	Double	\$1,634.00	\$ 0.00	\$1,634.00
	<input type="checkbox"/>	Family	\$2,269.00	\$ 0.00	\$2,269.00
Blue Shield ABHP/HSA	<input type="checkbox"/>	Single	\$ 877.00	\$ 759.36	\$ 117.64
	<input type="checkbox"/>	Double	\$1,844.00	\$ 0.00	\$1,844.00
	<input type="checkbox"/>	Family	\$2,560.00	\$ 0.00	\$2,560.00
Blue Shield HMO	<input type="checkbox"/>	Single	\$ 1,101.00	\$ 0.00	\$ 1,101.00
	<input type="checkbox"/>	Double	\$ 2,345.00	\$ 0.00	\$ 2,345.00
	<input type="checkbox"/>	Family	\$3,270.00	\$ 0.00	\$ 3,270.00
Blue Shield PPO	<input type="checkbox"/>	Single	\$ 1,225.00	\$ 0.00	\$1,225.00
	<input type="checkbox"/>	Double	\$2,619.00	\$ 0.00	\$2,619.00
	<input type="checkbox"/>	Family	\$3,656.00	\$ 0.00	\$3,656.00

I elect the coverage as indicated above.

I understand that the employee portion is subject to change based upon the Federal poverty Level, or changes to the ACA legislation or during open enrollment.

Employee Signature

Date
