

**CTFP**  
**Health Benefits Rates**

2023				
	Kaiser Permanente HMO		Kaiser Permanente HDHP with HSA	
Plan Benefit Category	Benefits In Network Only	Out of Network	In Network	Out of Network
Provider Network(s)	Kaiser Only	N/A	Kaiser Only	N/A
Calendar Year Deductible	None	N/A	\$3,000 individual/\$6,000 family	N/A
Annual Out of Pocket Max	\$1,500 individual/\$3,000 family	N/A	\$3,000 individual/\$6,000 family	N/A
Physician Office Visit	\$15	N/A	no charge after ded	N/A
Specialist Copay	\$15	N/A	no charge after ded	N/A
Preventative Care - Annual physical, labs, immunizations, well-woman, well-baby care, etc	no charge	N/A	ded waived/no charge	N/A
Pregnancy/Childbirth	No charge office visits/No charge delivery	N/A	no charge after ded	N/A
Non Preventative Lab/Xray	\$50 CT, MRI, PET/\$10 other	N/A	no charge after ded	N/A
Hospital - in patient	no charge	N/A	no charge after ded	N/A
Hospital - out patient	\$15	N/A	no charge after ded	N/A
Ambulance	\$100	\$100	no charge after ded	no charge after ded
Mental Health & Substance Abuse - inpatient	no charge	N/A	no charge after ded	N/A
Mental Health & Substance Abuse - outpatient	\$15 individual/\$5 group session for substance abuse, \$7 group session mental health	N/A	no charge after ded	N/A
Emergency room	\$100 (waived if admitted)	\$100 (waived if admitted)	no charge after ded	no charge after ded
Urgent care	\$15	\$15 some restrictions	no charge after ded	N/A
Durable medical equip	20% coinsurance	N/A	no charge after ded; up to \$2,500	N/A
Chiropractic care	\$15 (max 30 visits/year)	N/A	\$15 (up to 30 visits/year)	N/A
Prescriptions				
Pharmacy Benefits Manager	Kaiser Permanente		Kaiser Permanente	
Tier	Generic/Brand/Non Formulary		Generic/Brand/Non Formulary	
Tier	Generic/Brand/Non Formulary		Generic/Brand/Non Formulary	
Retail - 30 day supply	\$10/\$30/\$30	N/A	no charge after ded	N/A
Mail order - up to 100 day	\$20/\$60/\$60	N/A	no charge after ded	N/A
<b>Other Benefits - All Included with the Indicated Premium</b>				
Dental	See Ameritas Dental Plan for details. Max \$2,000 per person/per year in network, \$1,500 out of network. Out of network deductible.			
Vision	See VSP Vision Plan for details. Allowances for exams, frames, contact lenses.			
Life	Lincoln City Paid Life \$50,000/employee, \$10,000 spouse and each dependent child. Additional 100% Employee Paid Life available up to \$500,000 employee, \$25,000 spouse, \$2,000 each child. Conditions apply.			
EAP	Employee Assistance Plan: Up to 3 individual or family counseling visits per 6 months. Totally confidential. No co-pay.			
<b>This is not a contract. For more complete coverage details see the official plan documents. In case of any discrepancies, the official plan documents will govern.</b>				
Coverage Tier	Kaiser Permanente HMO		Kaiser Permanente HDHP with HSA	
Employee Only	\$53.22		\$0.00	
Employee plus Child(ren)	\$110.44		\$0.00	
Employee plus Spouse	\$131.84		\$0.00	
Employee plus Family	\$195.93		\$0.00	
<b>HSA City Contribution with HDHP</b>				
\$30.00				
\$60.00				
\$70.00				
\$100.00				

**Please Turn Over for Anthem**

**CTFP**  
Health Benefits Rates

2023					
	Anthem HMO	Anthem PPO		Anthem HDHP with HSA	
Plan Benefit Category	Benefits In Network Only	In Network	Out of Network	In Network	Out of Network
<b>Provider Network(s)</b>	Sante/Community Hospitals ***	St Agnes, Community Hospitals, Childrens Hospital ***		St Agnes, Community Hospitals, Childrens Hospital ***	
<b>Calendar Year Deductible</b>	None	\$500 individual/\$1,000 family	\$500 individual/\$1,000 family	\$3,000 individual/\$6,000 family	\$3,000 individual/\$6,000 family
<b>Annual Out of Pocket Max</b>	\$1,000 individual/\$2,000 family	\$3,000 individual/\$6,000 family	\$10,000 individual/\$20,000 family	\$3,000 individual/\$6,000 family	\$5,000 individual/\$10,000 family
<b>Physician Office Visit</b>	\$15	\$35 (deductible waived)	40% coinsurance after ded	no charge after ded	50% coinsurance after ded
<b>Specialist Copay</b>	\$15	\$35 (deductible waived)	40% coinsurance after ded	no charge after ded	50% coinsurance after ded
<b>Preventative Care - Annual physical, labs, immunizations, well-woman, well-baby care, etc</b>	no charge	no charge (deductible waived)	40% coinsurance after ded	ded waived/no charge	50% coinsurance
<b>Pregnancy/Childbirth</b>	No charge office visits/No charge delivery	\$35/visit ded waived/delivery \$250/admit + 20% coinsurance	40% coinsurance after ded	no charge after ded	50% coinsurance after ded
<b>Non Preventative Lab/Xray</b>	no charge	Lab/X-ray: no charge after ded; Advanced Imaging (MRI, PET, CAT scans): 20% coinsurance after ded	40% coinsurance after ded	no charge after ded	50% coinsurance after ded
<b>Hospital - in patient</b>	no charge	\$250/admit + 20% coinsurance after ded	40% coinsurance after ded up to \$600	no charge after ded	50% coinsurance after ded
<b>Hospital - out patient</b>	no charge	\$125/surgery + 20% coinsurance after ded	40% coinsurance after ded up to \$350	no charge after ded	50% coinsurance after ded up to \$350/day
<b>Ambulance</b>	no charge	20% coinsurance after ded	20% coinsurance after ded	no charge after ded	no charge after ded
<b>Mental Health &amp; Substance Abuse - inpatient</b>	no charge	\$250 admit + 20% coinsurance	40% coinsurance after ded	no charge after ded	50% coinsurance after ded
<b>Mental Health &amp; Substance Abuse - outpatient</b>	\$15	\$35	40% coinsurance after ded	no charge after ded	50% coinsurance after ded
<b>Emergency room</b>	\$100 (waived if admitted)	\$100 + 20% (coinsurance waived if admitted)	\$100 + 20% (coinsurance waived if admitted)	no charge after ded	no charge after ded
<b>Urgent care</b>	\$15	\$35 (deductible waived)	40% coinsurance after ded	no charge after ded	50% coinsurance after ded
<b>Durable medical equip</b>	no charge	20% coinsurance after ded	20% coinsurance after ded	no charge after ded	50% coinsurance after ded
<b>Chiropractic care</b>	\$10 or \$15/visit, see SBC	\$25/visit up to 12 visits	40% coinsurance after ded	no charge after ded (up to 24 visits/year)	50% coinsurance after ded
<b>Prescriptions</b>					
<b>Pharmacy Benefits Manager</b>	Ingenio (Anthem In House)	Express Scripts		Ingenio (Anthem In House)	
<b>Deductible</b>	Generic/Brand/Non Formulary	combined with health, OOPM* \$2,000 individual/\$4,000 family	does not apply to OOPM*	combined with health	combined with health
<b>Tier</b>	Generic/Brand/Non Formulary	Generic/Brand/Non Formulary	Generic/Brand/Non Formulary	Generic/Brand/Non Formulary	Generic/Brand/Non Formulary
<b>Retail - 30 day supply</b>	\$10/\$20/\$35	\$10/\$20/\$35	\$10/\$20/\$35	no charge after ded	50% coinsurance after ded
<b>Mail order - up to 100 day</b>	\$20/\$40/\$60	\$20/\$40/\$60	not covered	no charge after ded	not covered

**Other Benefits - All Included with the Indicated Premium**

<b>Dental</b>	See Ameritas Dental Plan for details. Max \$2,000 per person/per year in network, \$1,500 out of network. Out of network deductible.
<b>Vision</b>	See VSP Vision Plan for details. Allowances for exams, frames, contact lenses.
<b>Life</b>	Lincoln City Paid Life \$50,000/employee, \$10,000 spouse and each dependent child. Additional 100% Employee Paid Life available up to \$500,000 employee, \$25,000 spouse, \$2,000 each child. Conditions apply.
<b>EAP</b>	Employee Assistance Plan: Up to 3 individual or family counseling visits per 6 months. Totally confidential. No co-pay.

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Coverage Tier	Anthem HMO	Anthem PPO	Anthem HDHP with HSA
Employee Only	\$135.22	\$162.22	\$0.00
Employee plus Child(ren)	\$275.44	\$327.44	\$0.00
Employee plus Spouse	\$327.84	\$385.84	\$0.00
Employee plus Family	\$486.93	\$568.93	\$0.00

**Notes**

\*\*\* Provider networks subject to change. Hospitals & carriers negotiate contracts. Contract cycles & terms vary.

\* OOPM is out of pocket max

HSA City Contribution with HDHP
\$30.00
\$60.00
\$70.00
\$100.00

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