CPOA Health Benefits Rates

		2025				
	Kaiser Perman	ente 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	\$3,300 individual/\$6,600 family	N/A		
Annual Out of Pocket Max	\$1,500 individual/\$3,000 family	N/A	\$3,300 individual/\$6,600 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		
reventative Care - Annual physical, labs, nmunizations, well-woman, well-baby are, 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		
rescriptions						
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		N/A		
Mail order - up to 100 day	\$20/\$60/\$60	N/A	no charge after ded	IN/A		
Dther Benefits - All Included with th Dental Vision			k, \$1,500 out of network. Out of network deductit	ble.		
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 6 individual or family counseling visits per 6 months. Totally confidential. No co-pay.					
This is not a contract. For more com	plete coverage details see the official pla	n documents. In case of any discre	epancies, the official plan documents will gove	rn.		
Coverage Tier (per month)	Kaiser Permaner	nte HMO	Kaiser Permanente HDH	IP with HSA		
mployee Only	\$82.69		\$0.00			
mployee plus Child(ren)	\$145.70)	\$0.00			
mployee plus Spouse	\$169.19)	\$0.00			
Employee plus Family	\$239.87	,	\$0.00			
	I		HSA City Contribution	with HDHP		
		\$30.00				
			\$60.00			
			\$70.00			

\$100.00

CPOA Health Benefits Rates

		Health Be	025]			
	Anthem HMO			Anthem HDHP with HSA				
Plan Benefit Category	Benefits In Network Only	In Network	Out of Network	In Network	Out of Network			
Provider Network(s)	Sante/Community Hospitals ***	St Agnes, Community Hospitals, Childrens Hospital ***		St Agnes, Community Hospitals, Childrens Hospital ***				
Calendar Year Deductible	None	\$500 individual/\$1,000 family	\$500 individual/\$1,000 family	\$3,300 individual/\$6,600 family	\$3,300 individual/\$6,600 family			
Annual Out of Pocket Max	\$1,000 individual/\$2,000 family	\$3,000 individual/\$6,000 family	\$10,000 individual/\$20,000 family	\$3,300 individual/\$6,600 family	\$5,000 individual/\$10,000 family			
Physician Office Visit	\$15	\$35 (deductible waived)	40% coinsurance after ded	no charge after ded	50% coinsurance after ded			
Specialist Copay	\$15	\$35 (deductible waived)	40% coinsurance after ded	no charge after ded	50% coinsurance after ded			
Preventative Care - Annual physical, labs, immunizations, well-woman, well-baby care, etc	no charge	no charge (deductible waived)	40% coinsurance after ded	ded waived/no charge	50% coinsurance			
Pregnancy/Childbirth	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			
Non Preventative Lab/Xray	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			
Hospital - in patient	no charge	\$250/admit + 20% coinsurance after ded	40% coinsurance after ded up to \$600	no charge after ded	50% coinsurance after ded			
Hospital - out patient	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			
Ambulance	no charge	20% coinsurance after ded	20% coinsurance after ded	no charge after ded	no charge after ded			
Mental Health & Substance Abuse - inpatient	no charge	\$250 admit + 20% coinsurance	40% coinsurance after ded	no charge after ded	50% coinsurance after ded			
Mental Health & Substance Abuse - outpatient	\$15	\$35	40% coinsurance after ded	no charge after ded	50% coinsurance after ded			
Emergency room	\$100 (waived if admitted)	\$100 + 20% (coinsurance waived if admitted)	\$100 + 20% (coinsurance waived if admitted)	no charge after ded	no charge after ded			
Urgent care	\$15	\$35 (deductible waived)	40% coinsurance after ded	no charge after ded	50% coinsurance after ded			
Durable medical equip	no charge	20% coinsurance after ded	20% coinsurance after ded	no charge after ded	50% coinsurance after ded			
Chiropractic care	\$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			
Prescriptions								
Prescriptions Pharmacy Benefits Manager	Ingenio (Anthem In House)	Express Scripts		Ingenio (Anthem In House)				
	Ingenio (Anthem In House) Generic/Brand/Non Formulary	Express Scripts combined with health, OOPM* \$2,000 individual/\$4,000 family	does not apply to OOPM*	Ingenio (Anthem In House) combined with health	combined with health			
Pharmacy Benefits Manager		combined with health, OOPM* \$2,000	does not apply to OOPM* Generic/Brand/Non Formulary		combined with health Generic/Brand/Non Formulary			
Pharmacy Benefits Manager Deductible	Generic/Brand/Non Formulary	combined with health, OOPM* \$2,000 individual/\$4,000 family		combined with health				
Pharmacy Benefits Manager Deductible Tier	Generic/Brand/Non Formulary Generic/Brand/Non Formulary	combined with health, OOPM* \$2,000 individual/\$4,000 family Generic/Brand/Non Formulary	Generic/Brand/Non Formulary	combined with health Generic/Brand/Non Formulary	Generic/Brand/Non Formulary			
Pharmacy Benefits Manager Deductible Tier Retail - 30 day supply	Generic/Brand/Non Formulary Generic/Brand/Non Formulary \$10/\$20/\$35 \$20/\$40/\$60 with the Indicated Premium	combined with health, OOPM* \$2,000 individual/\$4,000 family Generic/Brand/Non Formulary \$10/\$20/\$35 \$20/\$40/\$60	Generic/Brand/Non Formulary \$10/\$20/\$35	combined with health Generic/Brand/Non Formulary no charge after ded no charge after ded	Generic/Brand/Non Formulary 50% coinsurance after ded			
Pharmacy Benefits Manager Deductible Tier Retail - 30 day supply Mail order - up to 100 day Other Benefits - All Included	Generic/Brand/Non Formulary Generic/Brand/Non Formulary \$10/\$20/\$35 \$20/\$40/\$60 with the Indicated Premium See Ameritas Dental Plan for det	combined with health, OOPM* \$2,000 individual/\$4,000 family Generic/Brand/Non Formulary \$10/\$20/\$35 \$20/\$40/\$60	Generic/Brand/Non Formulary \$10/\$20/\$35 not covered	combined with health Generic/Brand/Non Formulary no charge after ded no charge after ded	Generic/Brand/Non Formulary 50% coinsurance after ded			
Pharmacy Benefits Manager Deductible Tier Retail - 30 day supply Mail order - up to 100 day Other Benefits - All Included Dental	Generic/Brand/Non Formulary Generic/Brand/Non Formulary \$10/\$20/\$35 \$20/\$40/\$60 with the Indicated Premium See Ameritas Dental Plan for det See VSP Vision Plan for details.	combined with health, OOPM* \$2,000 individual/\$4,000 family Generic/Brand/Non Formulary \$10/\$20/\$35 \$20/\$40/\$60 ails. Max \$2,000 per person/per year Allowances for exams, frames, conta	Generic/Brand/Non Formulary \$10/\$20/\$35 not covered	combined with health Generic/Brand/Non Formulary no charge after ded no charge after ded but of network deductible.	Generic/Brand/Non Formulary 50% coinsurance after ded not covered			
Pharmacy Benefits Manager Deductible Tier Retail - 30 day supply Mail order - up to 100 day Other Benefits - All Included Dental Vision	Generic/Brand/Non Formulary Generic/Brand/Non Formulary \$10/\$20/\$35 \$20/\$40/\$60 with the Indicated Premium See Ameritas Dental Plan for det See VSP Vision Plan for details. Lincoln City Paid Life \$50,000/en spouse, \$2,000 each child. Conc	combined with health, OOPM* \$2,000 individual/\$4,000 family Generic/Brand/Non Formulary \$10/\$20/\$35 \$20/\$40/\$60 ails. Max \$2,000 per person/per year Allowances for exams, frames, conta aployee, \$10,000 spouse and each di ditions apply.	Generic/Brand/Non Formulary \$10/\$20/\$35 not covered r in network, \$1,500 out of network. C	combined with health Generic/Brand/Non Formulary no charge after ded no charge after ded but of network deductible.	Generic/Brand/Non Formulary 50% coinsurance after ded not covered			
Pharmacy Benefits Manager Deductible Tier Retail - 30 day supply Mail order - up to 100 day Other Benefits - All Included Dental Vision Life EAP	Generic/Brand/Non Formulary Generic/Brand/Non Formulary \$10/\$20/\$35 \$20/\$40/\$60 with the Indicated Premium See Ameritas Dental Plan for det See VSP Vision Plan for details. Lincoln City Paid Life \$50,000/en spouse, \$2,000 each child. Conc Employee Assistance Plan: Up to	combined with health, OOPM* \$2,000 individual/\$4,000 family Generic/Brand/Non Formulary \$10/\$20/\$35 \$20/\$40/\$60 ails. Max \$2,000 per person/per year Allowances for exams, frames, conta ployee, \$10,000 spouse and each d ditions apply.	Generic/Brand/Non Formulary \$10/\$20/\$35 not covered r in network, \$1,500 out of network. O ct lenses. ependent child. Additional 100% Emp	combined with health Generic/Brand/Non Formulary no charge after ded no charge after ded but of network deductible.	Generic/Brand/Non Formulary 50% coinsurance after ded not covered			
Pharmacy Benefits Manager Deductible Tier Retail - 30 day supply Mail order - up to 100 day Other Benefits - All Included Dental Vision Life EAP	Generic/Brand/Non Formulary Generic/Brand/Non Formulary \$10/\$20/\$35 \$20/\$40/\$60 with the Indicated Premium See Ameritas Dental Plan for det See VSP Vision Plan for details. Lincoln City Paid Life \$50,000/en spouse, \$2,000 each child. Conc Employee Assistance Plan: Up to	combined with health, OOPM* \$2,000 individual/\$4,000 family Generic/Brand/Non Formulary \$10/\$20/\$35 \$20/\$40/\$60 ails. Max \$2,000 per person/per year Allowances for exams, frames, conta apployee, \$10,000 spouse and each d ititions apply.	Generic/Brand/Non Formulary \$10/\$20/\$35 not covered r in network, \$1,500 out of network. C ct lenses. ependent child. Additional 100% Em ts per 6 months. Totally confidential. I	combined with health Generic/Brand/Non Formulary no charge after ded no charge after ded but of network deductible.	Generic/Brand/Non Formulary 50% coinsurance after ded not covered			
Pharmacy Benefits Manager Deductible Tier Retail - 30 day supply Mail order - up to 100 day Other Benefits - All Included Dental Vision Life EAP This is not a contract. For more	Generic/Brand/Non Formulary Generic/Brand/Non Formulary \$10/\$20/\$35 \$20/\$40/\$60 with the Indicated Premium See Ameritas Dental Plan for det See VSP Vision Plan for details Lincoln City Paid Life \$50,000/en spouse, \$2,000 each child. Conc Employee Assistance Plan: Up to re complete coverage details se	combined with health, OOPM* \$2,000 individual/\$4,000 family Generic/Brand/Non Formulary \$10/\$20/\$35 \$20/\$40/\$60 ails. Max \$2,000 per person/per year Allowances for exams, frames, conta apployee, \$10,000 spouse and each d ititions apply.	Generic/Brand/Non Formulary \$10/\$20/\$35 not covered r in network, \$1,500 out of network. O ct lenses. ependent child. Additional 100% Emp ts per 6 months. Totally confidential. I ase of any discrepancies, the offici m PPO	combined with health Generic/Brand/Non Formulary no charge after ded no charge after ded but of network deductible. ployee Paid Life available up to \$5 No co-pay.	Generic/Brand/Non Formulary 50% coinsurance after ded not covered			
Pharmacy Benefits Manager Deductible Tier Retail - 30 day supply Mail order - up to 100 day Other Benefits - All Included Dental Vision Life EAP This is not a contract. For monogeneration Coverage Tier (per month)	Generic/Brand/Non Formulary Generic/Brand/Non Formulary \$10/\$20/\$35 \$20/\$40/\$60 with the Indicated Premium See Ameritas Dental Plan for det See VSP Vision Plan for details Lincoln City Paid Life \$50,000/en spouse, \$2,000 each child. Conc Employee Assistance Plan: Up to re complete coverage details se Anthem HMO	combined with health, OOPM* \$2,000 individual/\$4,000 family Generic/Brand/Non Formulary \$10/\$20/\$35 \$20/\$40/\$60 ails. Max \$2,000 per person/per year Allowances for exams, frames, conta aployee, \$10,000 spouse and each d iltions apply. 6 individual or family counseling visi ase the official plan documents. In constants	Generic/Brand/Non Formulary \$10/\$20/\$35 not covered in network, \$1,500 out of network. C ct lenses. ependent child. Additional 100% Emp ts per 6 months. Totally confidential. I ase of any discrepancies, the offici m PPO 3.69	combined with health Generic/Brand/Non Formulary no charge after ded no charge after ded but of network deductible. Ployee Paid Life available up to \$5 No co-pay. al plan documents will govern. Anthem HDI	Generic/Brand/Non Formulary 50% coinsurance after ded not covered 00,000 employee, \$25,000 HP with HSA 00			
Pharmacy Benefits Manager Deductible Tier Retail - 30 day supply Mail order - up to 100 day Other Benefits - All Included Dental Vision Life EAP This is not a contract. For more coverage Tier (per month) Employee Only	Generic/Brand/Non Formulary Generic/Brand/Non Formulary \$10/\$20/\$35 \$20/\$40/\$60 with the Indicated Premium See Ameritas Dental Plan for det See VSP Vision Plan for details. J Lincoln City Paid Life \$50,000/en spouse, \$2,000 each child. Conc Employee Assistance Plan: Up to re complete coverage details se Anthem HMO \$173.69	combined with health, OOPM* \$2,000 individual/\$4,000 family Generic/Brand/Non Formulary \$10/\$20/\$35 \$20/\$40/\$60 ails. Max \$2,000 per person/per year Allowances for exams, frames, conta aployee, \$10,000 spouse and each d ditions apply. 6 individual or family counseling visi ee the official plan documents. In co Anthe \$200	Generic/Brand/Non Formulary \$10/\$20/\$35 not covered in network, \$1,500 out of network. C ct lenses. ependent child. Additional 100% Em ts per 6 months. Totally confidential. I ase of any discrepancies, the offici m PPO 3.69 3.70	combined with health Generic/Brand/Non Formulary no charge after ded no charge after ded but of network deductible. ployee Paid Life available up to \$5 No co-pay. al plan documents will govern. Anthem HDI	Generic/Brand/Non Formulary 50% coinsurance after ded not covered 00,000 employee, \$25,000 HP with HSA 00 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