CTFP
Health Benefits Rates

2025				
	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	$3,300 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
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

Other Benefits - All Included with the Indicated Premium	
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.

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.

Coverage Tier (per month)	Kaiser Permanente HMO	Kaiser Permanente HDHP with HSA
Employee Only	$69.02	$0.00
Employee plus Child(ren)	$132.03	$0.00
Employee plus Spouse	$155.52	$0.00
Employee plus Family	$226.20	$0.00

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

Please Turn Over for Anthem

CTFP
Health Benefits Rates

2025					
	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
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					
Pharmacy Benefits Manager	Ingenio (Anthem In House)	Express Scripts		Ingenio (Anthem In House)	
Deductible	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
Tier	Generic/Brand/Non Formulary	Generic/Brand/Non Formulary	Generic/Brand/Non Formulary	Generic/Brand/Non Formulary	Generic/Brand/Non Formulary
Retail - 30 day supply	$10/$20/$35	$10/$20/$35	$10/$20/$35	no charge after ded	50% coinsurance after ded
Mail order - up to 100 day	$20/$40/$60	$20/$40/$60	not covered	no charge after ded	not covered

Other Benefits - All Included with the Indicated Premium	
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.

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Coverage Tier (per month)	**Anthem HMO**	**Anthem PPO**	**Anthem HDHP with HSA**	**HSA City Contribution with HDHP**
Employee Only	$160.02	$190.02	$0.00	$30.00
Employee plus Child(ren)	$316.03	$373.03	$0.00	$60.00
Employee plus Spouse	$374.52	$438.52	$0.00	$70.00
Employee plus Family	$549.20	$640.20	$0.00	$100.00

Notes

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

*** OOPM is out of pocket max**

Please Turn Over for Kaiser