Health Insurance Plan Options and Employee Premium Rates SPEU Part-time CSO 2024

MEDICAL COVERAGE

	Opt-Out Plan	Cigna HDHP & HRAVEBA	Cigna PPO OAP	Kaiser Permanente
	Have other coverage and want to save money for future health care expenses? Waive City coverage to receive contributions to an HRAVEBA	*Want a way to save money for health care costs that is exempt from taxes? Choose this qualifying medical plan that is paired with a HRAVEBA*	*A traditional medical plan with higher monthly premiums, but lower deductible and annual out-of-pocket maximum*	*Want one-stop shopping for your medical needs? Choose this plan to receive coordinated care*

Monthly Premium Rates and/or Contribution	**City HRAVEBA Contribution:**	**You Pay:**	**City HRAVEBA Contribution:**	**You Pay:**	**You Pay:**
Employee Only	$135.00 *Pro-rated for part-time Must provide proof of other qualifying health insurance such as other employer health insurance to receive incentive funds. Funds will be contributed to an HRAVEBA account	$201.11	$80.00	$428.47	$396.39
Employee + Spouse/DP		$402.21	$160.00	$790.92	$726.80
Employee + Child(ren)		$382.10	$160.00	$754.68	$693.75
Employee + Family		$583.21	$160.00	$1117.13	$1024.16
		*Pro-rated	*Pro-rated	*Pro-rated	*Pro-rated

Deductible & Out-of-Pocket Max	Cigna HDHP: **1 party**	Cigna HDHP: **Family (2 party +)**	Cigna PPO: **1 party**	Cigna PPO: **2 party**	Cigna PPO: **Family**	Kaiser: **1 party**	Kaiser: **2 party**	Kaiser: **Family**
In-Network Deductible	$1,600	$3,200 Non-Embedded deductible	$250	$500	$750	$250	$500	$750
Out-of-Network Deductible	$3,000	$6,000 Non-Embedded deductible	N/A	N/A	N/A	N/A	N/A	N/A
In-Network Annual Out-of-Pocket Maximum	$6,350	$12,700 $6,650 per person	$1,250	$2,500	$3,750	$1,250	$2,500	$3,750
Out-of-Network Annual Out-of-Pocket Maximum	$12,700	$25,400	$2,250	$4,500	$6,750	N/A	N/A	N/A

Medical Services per member	Cigna HDHP: **In-Network You Pay:**	Cigna HDHP: **Out-of-Network You Pay:**	Cigna PPO: **In-Network You Pay:**	Cigna PPO: **Out-of-Network You Pay:**	Kaiser: **You Pay:**
Preventive Care	$0; Deductible Waived	40%	$0; Deductible Waived	40%	$0; Deductible Waived
Office Visits	20%	40%	20%	40%	$15 Primary / $25 Specialist
Lab & X-Ray Services	20%	40%	20%	40%	$10 per visit
Hearing Aids and testing	$0 after deductible Maximum of 2 devices per 36 months		$0 after deductible Maximum of 2 devices per 36 months		$0 after deductible Maximum of 2 devices per 36 months
Mental Illness/ Chemical Dependency	20%	40%	20%	40%	$15 Outpatient 20% Inpatient & Residential
Maternity Global fee	10%	40%	10%	40%	$0
Hospital Stay	20%	40%	20%	40%	20%
Outpatient Surgery	20%	40%	20%	40%	20%
Emergency Room (True Emergency)	20%		$100 per visit Deductible Waived		20%
Emergency Room (Non-Emergency)	20%		$100 per visit plus 20% Deductible Waived	$100 per visit, plus 40% Deductible Waived	20%
Urgent Care	20%	40%	$50 per visit Deductible Waived	40%	$15 per visit
Ambulance	20%		20%		20%
Durable Medical Equipment	20%	40%	20%	40%	20%
Inpatient Rehabilitation Outpatient Rehabilitation (Physical, Speech, Occupational therapy)	20% inpatient 20%; Up to 30 visits per calendar year	40% inpatient 40%; Up to 30 visits per calendar year	20% inpatient 20%; Up to 30 visits per calendar year	40% inpatient 40%; Up to 30 visits per calendar year.	20% inpatient $25 per visit Physical, Speech, Occupational therapy. up to 20 visits per therapy/year
Alternative Care Chiropractic Care, Massage Therapy, Acupuncture	20% after Deductible Chiropractic Care (includes massage therapy): limited to 20 visits per calendar year; Acupuncture limited to 12 visits per calendar year		$10 per visit Deductible Waived Chiropractic Care (includes massage therapy): limited to 20 visits per calendar year; Acupuncture limited to 12 visits per calendar year		Chiropractic Care $10 per visit; limited to 20 visits per calendar year Acupuncture $10 per visit; limited to 12 visits per calendar year Massage Therapy $25 per visit; limited to 12 visits per calendar year
Routine Eye Exam	Covered by vision plan	Covered by vision plan	Covered by vision plan	Covered by vision plan	$15 per visit

This is a brief outline of the City of Salem health plan coverage. If there is a discrepancy between this summary and the plan document, the plan document will prevail. Refer to the Summary Plan Document (SPD) for the health plan's terms and conditions.

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PRESCRIPTION COVERAGE

Included with medical plan	Cigna HDHP		Cigna PPO OAP			Kaiser Permanente		
	1 party	**Family (2 party +)**	**1 party**	**2 party**	**Family**	**1 party**	**2 party**	**Family**
Deductible	Subject to $1,600 HDHP Deductible	Subject to $3,000 HDHP Deductible	$0	$0	$0	$0	$0	$0
Annual Out-of-Pocket Maximum	Accrues to medical out-of-pocket max	Accrues to medical out-of-pocket max	$2,000	$4,000	$6,000	Accrues to medical out-of-pocket max	Accrues to medical out-of-pocket max	Accrues to medical out-of-pocket max
Retail- 30-Day Supply	**In-Network You Pay:**	**Out-of-Network You Pay:**	**In-Network You Pay:**		**Out-of-Network You Pay:**	**You Pay:**		
Generic	20%	100%, then request reimbursement	$10 co-pay		100%, then request reimbursement	$10 co-pay		
Preferred*	20%		30%: $25 min / $50 max			$20 co-pay		
Non-Preferred	20%		30%: $45 min / $75max			$40 co-pay		
Mail Order- 90-Day Supply	**In-Network You Pay:**	**Out-of-Network You Pay:**	**In-Network You Pay:**		**Out-of-Network You Pay:**	**You Pay:**		
Generic	20%	Not Available	$20 co-pay		Not Available	$20 co-pay		
Preferred*	20%		30%: $25 min / $100 max			$40 co-pay		
Non-Preferred	20%		30%: $45 min / $120 max			$80 co-pay		

***Preferred drug list is subject to change without notice*.**

VISION COVERAGE

Monthly Premium Rates	Cigna $500 Vision	Kaiser Permanente Vision
Employee Only Employee + Spouse Employee + Child(ren) Employee + Family	$7.37 $14.74 $14.00 $21.38 *Pro-rated	Included in medical premium
Vision Services per member	**Plan Pays:**	**Plan Pays:**
Routine Eye Exam	100% allowed charges once per calendar year	Vision exams covered by medical plan
Vision Materials: Frames, Lenses, Contact Lenses	Up to $500 allowance every two calendar years for any combination of frames, lenses, or contacts	Vision materials not covered by Kaiser. Kaiser medical plan members may enroll in the Cigna $500 vision plan

Cigna preferred vision providers can be found online in the Cigna provider directory. Out-of-network vision providers may require you to submit a manual claim for reimbursement to Cigna. Your Frequency Period begins January 1 every year for exams and January 1 every other year for hardware.

DENTAL COVERAGE

Monthly Premium Rates	Willamette Dental	Moda Traditional Dental With Preventative First	Moda Incentive Dental *(Closed to new enrollment)*
Employee Only Employee + Spouse Employee + Child(ren) Employee + Family	$19.52 $38.98 $37.04 $56.54 *Pro-rated	$24.86 $49.72 $47.23 $72.08 *Pro-rated	$24.61 $49.20 $46.74 $71.34 *Pro-rated
Dental Services per member	**Plan Pays:**	**Plan Pays:**	**Plan Pays:**
Calendar Year Maximum per member	No Limit	$1,800	$1,000
Preventive: Exams, X-Rays, Cleanings, Sealants, Fluoride	100% after co-pay Routine Office Visit: $10 co-pay Specialist Office Visit: $30 co-pay	100% *Not included in calendar year maximum	70% - 1st year* 80% - 2nd year 90% - 3rd year 100% - 4th year *Must see dentist every year to increase and maintain benefit level
Basic: Fillings, Surgery, Endodontics, Periodontics	100% after co-pay $65-$150 co-pay per service; Fillings covered with office visit co-pay.	80%	
Major: Crowns and other cast restorations	100% after $150 co-pay	60%	
Major: Dentures and Bridges	100% after co-pay Bridge: $150 co-pay per tooth; Upper or Lower Denture: $200 co-pay		50%
Orthodontia	100% after $1,800 co-pay	50%: $1,000 lifetime max	50%: $1,000 lifetime max

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