

# Health Insurance Plan Options and Employee Premium Rates IAFF 2025

## MEDICAL COVERAGE

|  | <b>Opt-Out Plan</b><br><i>Have other coverage and want to save money for future health care expenses? Waive City coverage to receive contributions to an HRAVEBA</i>  | <b>Cigna HDHP &amp; HRAVEBA</b><br><i>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</i> |                                    | <b>Cigna PPO OAP</b><br><i>A traditional medical plan with higher monthly premiums, but lower deductible and annual out-of-pocket maximum</i> |                |   | <b>Kaiser Permanente</b><br><i>Want one-stop shopping for your medical needs? Choose this plan to receive coordinated care</i> |  |               |  |  |
|--|---|---|------------------------------------|---|----------------|---|--|--|---------------|--|--|
| <b>Monthly Premium Rates and/or Contribution</b>                   | <b>City HRAVEBA Contribution:</b>   | <b>You Pay:</b>   | <b>City HRAVEBA Contribution:</b>  | <b>You Pay:</b>   |                |   | <b>You Pay:</b>  |  |               |  |  |
| Employee Only  | \$225<br><br>*Pro-rated for part-time<br><br>Must provide proof of other qualifying health insurance such as other employer health insurance to receive incentive funds.<br><br>Funds will be contributed to an HRAVEBA account | \$0.00  | \$137.50                           | \$49.39   |                |   | \$41.30  |  |               |  |  |
| Employee + Spouse/DP   |   | \$0.00  | \$275.00                           | \$98.77   |                |   | \$82.60  |  |               |  |  |
| Employee + Child(ren)  |   | \$0.00  | \$275.00                           | \$93.84   |                |   | \$78.47  |  |               |  |  |
| Employee + Family  |   | \$0.00  | \$275.00                           | \$143.22  |                |   | \$119.77   |  |               |  |  |
|  |   | *Pro-rated for part-time  | *Pro-rated for part-time           | *Pro-rated for part-time  |                |   | *Pro-rated for part-time   |  |               |  |  |
| <b>Deductible &amp; Out-of-Pocket Max</b>                          |   | <b>1 party</b>  | <b>Family (2 party +)</b>          | <b>1 party</b>  | <b>2 party</b> | <b>Family</b>   | <b>1 party</b>   | <b>2 party</b>   | <b>Family</b> |  |  |
| In-Network Deductible  |   | \$1,650   | \$3,200<br>Non-Embedded deductible | \$250   | \$500          | \$750   | \$250  | \$500  | \$750         |  |  |
| Out-of-Network Deductible  |   | \$3,300   | \$6,000<br>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<br>\$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           |  |  |
| <b>Medical Services per member</b>                                 |   | <b>In-Network You Pay:</b>  | <b>Out-of-Network You Pay:</b>     | <b>In-Network You Pay:</b>  |                | <b>Out-of-Network You Pay:</b>  | <b>You Pay:</b>  |  |               |  |  |
| 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<br>Maximum of 2 devices per 36 months  |                                    | \$0 after deductible<br>Maximum of 2 devices per 36 months  |                | \$0 after deductible<br>Maximum of 2 devices per 36 months  |  |  |               |  |  |
| Mental Illness/ Chemical Dependency                                |   | 20%   | 40%                                | 20%   |                | 40%   | \$15 Outpatient<br>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<br>Deductible Waived  |                | 20%   |  |  |               |  |  |
| Emergency Room (Non-Emergency)                                     |   | 20%   |                                    | \$100 per visit<br>plus 20% Deductible Waived   |                | \$100 per visit,<br>plus 40% Deductible Waived  |  | 20%  |               |  |  |
| Urgent Care  |   | 20%   | 40%                                | \$50 per visit<br>Deductible Waived   |                | 40%   |  | \$15 per visit   |               |  |  |
| Ambulance  |   | 20%   |                                    | 20%   |                | 20%   |  |  |               |  |  |
| Durable Medical Equipment  |   | 20%   | 40%                                | 20%   |                | 40%   |  | 20%  |               |  |  |
| Inpatient Rehabilitation   |   | 20% inpatient   |                                    | 40% inpatient   |                | 20% inpatient   |  | 40% inpatient  |               | 20% inpatient  |  |
| Outpatient Rehabilitation (Physical, Speech, Occupational therapy) |   | 20%; Up to 30 visits per calendar year  |                                    | 40%; Up to 30 visits per calendar year  |                | 20%; Up to 30 visits per calendar year  |  | 40%; Up to 30 visits per calendar year.  |               | \$25 per visit<br>Physical, Speech, Occupational therapy. up to 20 visits per therapy/year |  |
| Alternative Care (Chiropractic Care, Massage Therapy, Acupuncture) |   | 20% after Deductible  |                                    | \$10 per visit<br>Deductible Waived   |                | Chiropractic Care (includes massage therapy): limited to 20 visits per calendar year;<br>Acupuncture limited to 12 visits per calendar year |  | Chiropractic Care \$10 per visit; limited to 20 visits per calendar year<br>Acupuncture \$10 per visit; limited to 12 visits per calendar year<br>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 \$1,650 HDHP Deductible   | Subject to \$3,300 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 |
| <b>Retail-30-Day Supply</b>     | <b>In-Network You Pay:</b>           | <b>Out-of-Network You Pay:</b>       | <b>In-Network You Pay:</b>   | <b>Out-of-Network You Pay:</b>   | <b>Out-of-Network You Pay:</b> | <b>You Pay:</b>                      |                                      |                                      |
| Generic                         | 20%                                  | 100%, then request reimbursement     | \$10 co-pay                  | 100%, then request reimbursement |                                | \$10 co-pay                          |                                      |                                      |
| Preferred*                      | 20%                                  |                                      | 30%:<br>\$25 min / \$50 max  |                                  |                                | \$20 co-pay                          |                                      |                                      |
| Non-Preferred                   | 20%                                  |                                      | 30%:<br>\$45 min / \$75max   |                                  |                                | \$40 co-pay                          |                                      |                                      |
| <b>Mail Order-90-Day Supply</b> | <b>In-Network You Pay:</b>           | <b>Out-of-Network You Pay:</b>       | <b>In-Network You Pay:</b>   | <b>Out-of-Network You Pay:</b>   | <b>Out-of-Network You Pay:</b> | <b>You Pay:</b>                      |                                      |                                      |
| Generic                         | 20%                                  | Not Available                        | \$20 co-pay                  | Not Available                    |                                | \$20 co-pay                          |                                      |                                      |
| Preferred*                      | 20%                                  |                                      | 30%:<br>\$25 min / \$100 max |                                  |                                | \$40 co-pay                          |                                      |                                      |
| Non-Preferred                   | 20%                                  |                                      | 30%:<br>\$45 min / \$120 max |                                  |                                | \$80 co-pay                          |                                      |                                      |

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

## VISION COVERAGE

| Monthly Premium Rates                            | Cigna Vision  | Kaiser Permanente Vision  |
|--|---|---|
| Employee Only                                    | \$0.93  | Included in medical premium   |
| Employee + Spouse                                | \$1.85  |   |
| Employee + Child(ren)                            | \$1.76  |   |
| Employee + Family                                | \$2.68<br><small>*Pro-rated for part-time</small>   |   |
| 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  |
|--|---|---|--|
| Employee Only  | \$2.57  | \$3.11  | \$3.08   |
| Employee + Spouse  | \$5.12  | \$6.22  | \$6.15   |
| Employee + Child(ren)                                    | \$4.87  | \$5.91  | \$5.85   |
| Employee + Family  | \$7.43<br><small>*Pro-rated for part-time</small>   | \$9.02<br><small>*Pro-rated for part-time</small>             | \$8.92<br><small>*Pro-rated for part-time</small>  |
| 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<br>Routine Office Visit: \$10 co-pay<br>Specialist Office Visit: \$30 co-pay    | 100%<br><small>*Not included in calendar year maximum</small> | 70% - 1 <sup>st</sup> year*<br>80% - 2 <sup>nd</sup> year<br>90% - 3 <sup>rd</sup> year<br>100% - 4 <sup>th</sup> year |
| Basic: Fillings, Surgery, Endodontics, Periodontics      | 100% after co-pay<br>\$65-\$150 co-pay per service;<br>Fillings covered with office visit co-pay. | 80%   | <small>*Must see dentist every year to increase and maintain benefit level</small>                                     |
| Major: Crowns and other cast restorations                | 100% after \$150 co-pay   | 60%   |  |
| Major: Dentures and Bridges                              | 100% after co-pay<br>Bridge: \$150 co-pay per tooth;<br>Upper or Lower Denture: \$200 co-pay      |   | 50%  |
| Orthodontia  | 100% after \$1,800 co-pay   | 50%: \$1,500 lifetime max                                     | 50%: \$1,000 lifetime max  |

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