Health Insurance Plan Options and Employee Premium Rates AFSCME, SCABU, PCEA, Unrepresented 2025

MEDICAL COVERAGE

	Opt-Out Plan *Have other coverage and want to save money for future health care expenses? Waive City coverage to receive contributions to an HSA or HRAVEBA*	**Cigna HDHP & HSA** *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 Health Savings Account (HSA)*		***Cigna PPO OAP*** *A traditional medical plan with higher monthly premiums, but lower deductible and annual out-of-pocket maximum*			***Kaiser Permanente*** *Want one-stop shopping for your medical needs? Choose this plan to receive coordinated care*		
Monthly Premium Rates and/or Contribution	**City HSA or HRAVEBA Contribution:**	**You Pay:**	**City HSA Contribution:**	**You Pay:**			**You Pay:**		
Employee Only	$225 *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 unless your other health insurance is a HDHP medical plan. You must have a HDHP medical plan to receive contributions to an HSA.	$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 *Pro-rated for part-time	$275.00 *Pro-rated for part-time	$143.22 *Pro-rated for part-time			$119.77 *Pro-rated for part-time		
Deductible & Out-of-Pocket Max		**1 party**	**Family (2 party +)**	**1 party**	**2 party**	**Family**	**1 party**	**2 party**	**Family**
In-Network Deductible		$1,650	$3,200 Non-Embedded deductible	$250	$500	$750	$250	$500	$750
Out-of-Network Deductible		$3,300	$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		**In-Network You Pay:**	**Out-of-Network You Pay:**	**In-Network You Pay:**		**Out-of-Network You Pay:**	**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 $1,650 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
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 Vision**	**Kaiser Permanente Vision**
Employee Only Employee + Spouse Employee + Child(ren) Employee + Family	$0.93 $1.85 $1.76 $2.68 *Pro-rated for part-time	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 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	$2.57 $5.12 $4.87 $7.43 *Pro-rated for part-time	$3.11 $6.22 $5.91 $9.02 *Pro-rated for part-time	$3.08 $6.15 $5.85 $8.92 *Pro-rated for part-time
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%: $1,500 lifetime max	50%: $1,000 lifetime max

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