

Health Insurance Plan Options and Employee Premium Rates IAFF 2026

MEDICAL COVERAGE

	Opt-Out Plan <i>Have other coverage and want to save money for future health care expenses? Waive City coverage to receive contributions to an HRAVEBA</i>	Cigna HDHP & HRAVEBA <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 an HRAVEBA contribution</i> <i>HSA not allowed per IRS rules</i>		Cigna PPO OAP <i>A traditional medical plan with higher monthly premiums, but lower deductible and annual out-of-pocket maximum</i>			Kaiser Permanente <i>Want one-stop shopping for your medical needs? Choose this plan to receive coordinated care</i>		
Monthly Premium Rates and/or Contribution	City HRAVEBA Contribution:	You Pay:	City HRAVEBA Contribution:	You Pay:			You Pay:		
Employee Only	\$225 *Pro-rated for part-time	\$0.00	\$141.67	\$58.28			\$45.43		
Employee + Spouse/DP		\$0.00	\$283.34	\$116.55			\$90.86		
Employee + Child(ren)		\$0.00	\$283.34	\$110.73			\$86.32		
Employee + Family		\$0.00	\$283.34	\$169.00			\$131.75		
		*Pro-rated for part-time	*Pro-rated for part-time	*Pro-rated for part-time			*Pro-rated for part-time		
Deductible & Out-of-Pocket Max	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	1 party	Family (2 party +)	1 party	2 party	Family	1 party	2 party	Family
In-Network Deductible		\$1,700	\$3,400 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		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%			
Ambulance		20%		20%				20%	
Durable Medical Equipment		20%	40%	20%		40%			
Inpatient Rehabilitation		20% inpatient	40% inpatient	20% inpatient		40% 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 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 HDHP Deductible	Subject to 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:	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:	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	\$0.93	Included in medical premium
Employee + Spouse	\$1.85	
Employee + Child(ren)	\$1.76	
Employee + Family	\$2.68 <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 Closed to new enrollment
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 <small>*Pro-rated for part-time</small>	\$9.02 <small>*Pro-rated for part-time</small>	\$8.92 <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 Routine Office Visit: \$10 co-pay Specialist Office Visit: \$30 co-pay	100% <small>*Not included in calendar year maximum</small>	70% - 1 st year* 80% - 2 nd year 90% - 3 rd year 100% - 4 th year
Basic: Fillings, Surgery, Endodontics, Periodontics	100% after co-pay \$65-\$150 co-pay per service; 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 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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