

Health Insurance Plan Options and Employee Premium Rates Full-time AFSCME, SCABU, PCEA, Unrepresented 2026

MEDICAL COVERAGE

| | Opt-Out Plan | Cigna HDHP & HSA | | Cigna PPO OAP | | | Kaiser Permanente | | |
|---|--|---|--|---|--|---|--|----------------|---------------|
| | <i>Have other coverage and want to save money for future health care expenses? Waive City coverage to receive contributions to an HRAVEBA</i> | <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 Health Savings Account (HSA)</i> | | <i>A traditional medical plan with higher monthly premiums, but lower deductible and annual out-of-pocket maximum</i> | | | <i>Want one-stop shopping for your medical needs? Choose this plan to receive coordinated care</i> | | |
| | | <i>Contribution will be to the HRAVEBA account if an HSA is not allowed per IRS restrictions</i> | | | | | | | |
| Monthly Premium Rates and/or Contribution | City HSA or HRAVEBA Contribution: | You Pay: | City HSA or HRAVEBA Contribution: | You Pay: | | | You Pay: | | |
| Employee Only | \$225 | \$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 | | | *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. | | | | | | | | |
| Deductible & Out-of-Pocket Max | | 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% | \$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 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 <small>*Must see dentist every year to increase and maintain benefit level</small> |
| 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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