Health Insurance Plan Options and Employee Premium Rates SPEU Part-time CSO 2026

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* *HSA not allowed per IRS rules*	*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		$201.11	$85.00	$544.21	$441.43
Employee + Spouse/DP	$135.00	$402.21	$170.00	$,1010.39	$804.88
Employee + Child(ren)		$382.10	$170.00	$963.78	$768.53
Employee + Family	*Pro-rated for part-time	$583.21	$170.00	$1,429.96	$1,131.98
		*Pro-rated	*Pro-rated	*Pro-rated	*Pro-rated

Opt-Out Plan: 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

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	$1,700	$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	**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.

Health Insurance Plan Options and Employee Premium Rates SPEU Part-time CSO 2026

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:**	**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	$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 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	$20.50 $40.93 $38.89 $59.37 *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%: $1,500 lifetime max	50%: $1,000 lifetime max

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