IAFF Health Insurance Plan Options and Employee Premium Rates 2020

MEDICAL COVERAGE

	EBMS HDHP & HSA	***EBMS PPO***	***Kaiser Permanente***
	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)	*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	**You Pay:**	**You Pay:**	**You Pay:**
Employee Only	$25.14	$35.96	$32.37
Employee + Spouse	$50.28	$71.91	$64.73
Employee + Child(ren)	$47.77	$68.32	$61.50
Employee + Family	$72.91	$104.27	$93.86

Deductible & Out-of-Pocket Max	**EBMS HDHP & HSA: 1 party**	**EBMS HDHP & HSA: Family (2 party +)**	**EBMS PPO: 1 party**	**EBMS PPO: 2 party**	**EBMS PPO: Family**	**Kaiser: 1 party**	**Kaiser: 2 party**	**Kaiser: Family**
In-Network Deductible	$1,500	$3,000 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	**EBMS HDHP & HSA: In-Network You Pay:**	**EBMS HDHP & HSA: Out-of-Network You Pay:**	**EBMS PPO: In-Network You Pay:**	**EBMS PPO: Out-of-Network You Pay:**	**Kaiser Permanente: 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	100% after deductible; $2,000 benefit max every 24 months, up to age 26		100% after deductible; $2,000 benefit max every 24 months, up to age 26		20% up to age 26
Mental Illness/ Chemical Dependency	20%	40%	20%	40%	$15 Outpatient 20% Inpatient & Residential
Maternity Provider	20%	40%	20%	40%	No Charge
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 (Note: Non-alternative care provided by a Naturopath is covered under office visits)	20% $500 Benefit Max	40% $500 Benefit Max	$10 per visit Deductible Waived $500 Combined Benefit Maximum per calendar year for Chiropractic and Acupuncture Care		$10 per visit Acupuncture, Chiropractic, Naturopathic $25 per visit Massage Therapy (max 12 visits per year) $1,000 Combined Benefit Maximum 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	Optum Rx HDHP		Optum Rx PPO			Kaiser Permanente		
	1 party	Family (2 party +)	1 party	2 party	Family	1 party	2 party	Family
Deductible	Subject to $1,500 HDHP Deductible	Subject to $3,000 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**.

Please refer to www.optumrx.com for a current listing of preferred drugs.

VISION COVERAGE

Monthly Premium Rates	EBMS Traditional Vision *(Closed to new enrollment)*	EBMS $500 Vision	Kaiser Permanente Vision
Employee Only Employee + Spouse Employee + Child(ren) Employee + Family	$0.49 $0.98 $0.93 $1.42	$0.93 $1.85 $1.76 $2.68	Included in medical premium
Vision Services per member	**Plan Pays:**	**Plan Pays:**	**Plan Pays:**
Routine Eye Exam Frequency	Once per calendar year	Once per calendar year	Exams covered by medical plan
Routine Eye Exam (Under age 19)	100% (in-network) $25 (out-of-network)	100% (in-network) 40% (out-of-network)	
Routine Eye Exam (Age 19+)	100% (in-network) $25 (out-of-network)	Up to $500 every two calendar years for any combination of routine eye exam, frames, lenses, or contacts (Renews odd years)	
Frames	$40 once per 24 months		Not covered. Kaiser Permanente medical members may enroll in the EBMS $500 vision plan
Lenses	$89 - Single Vision $125 - Bifocal $158 – Trifocal $50 – Lenticular		
Contact Lenses	$100 per calendar year		

DENTAL COVERAGE

Monthly Premium Rates	Willamette Dental	Moda (ODS) Traditional Dental With Preventative First	Moda (ODS) Incentive Dental
Employee Only Employee + Spouse Employee + Child(ren) Employee + Family	$2.78 $5.56 $5.28 $8.06	$3.11 $6.22 $5.91 $9.02	$3.08 $6.15 $5.85 $8.92
Dental Services per member	**Plan Pays:**	**Plan Pays:**	**Plan Pays:**
Calendar Year Maximum per member	No Limit	$1,500	$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 100% after co-pay	60%	
Major: Dentures and Bridges	Bridge: $150 co-pay per tooth; Upper or Lower Denture: $200 co-pay		50%
Orthodontia	100% after $1,800 co-pay	50%: $1,000 lifetime max	50%: $1,000 lifetime max

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