

AFSCME Health Insurance Plan Options and Employee Premium Rates 2019

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 HSA or HRAVEBA</i>	EBMS HDHP & HSA <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>		EBMS PPO <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 HSA or HRAVEBA Contribution:	You Pay:	City HSA Contribution:	You Pay:			You Pay:	
Employee Only Employee + Spouse Employee + Child(ren) Employee + Family	\$225 *Pro-rated for part-time	\$0.00 \$0.00 \$0.00 \$0.00	\$81.84 \$237.34 \$237.34 \$237.34	\$35.08 \$70.16 \$66.65 \$101.73			\$30.00 \$59.99 \$56.99 \$86.99	
Deductible & Out-of-Pocket Max		Single	Family	Single	2-Party	Family	Single	Family
In-Network Deductible		\$1,500	\$3,000	\$250	\$500	\$750	\$250	\$750
Out-of-Network Deductible		\$3,000	\$6,000	N/A	N/A	N/A	N/A	N/A
In-Network Annual Out-of-Pocket Maximum		\$6,350	\$12,700	\$1,250	\$2,500	\$3,750	\$1,250	\$3,750
Out-of-Network Annual Out-of-Pocket Maximum		\$12,700	\$25,400	\$2,250	\$4,500	\$6,750	N/A	N/A
Medical Services		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		20% after deductible; \$4,500 benefit max every 48 months, up to age 26		0% after deductible; \$4,500 benefit max every 48 months, up to age 26		20%; 1 per ear every four years, up to age 19		
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%	
Outpatient / Inpatient Rehabilitation (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 after Deductible 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	
	Single	Family	Single	2-Party	Family	Single	Family
Deductible	Subject to \$1,500 HDHP Deductible	Subject to \$3,000 HDHP Deductible	\$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
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 / \$55 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%: \$50 min / \$110 max		\$40 co-pay		
Non-Preferred	20%		30%: \$90 min / \$150 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	\$0.49	\$0.93	Included in medical premium.
Employee + Spouse	\$0.98	\$1.85	
Employee + Child(ren)	\$0.93	\$1.76	
Employee + Family	\$1.42	\$2.68	
Vision Services per member	Plan Pays:	Plan Pays:	Plan Pays:
Routine Eye Exam Frequency	Once per calendar year	Once per calendar year	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 even years)	
Frames	\$40 once per 24 months		
Lenses	\$89 - Single Vision \$125 - Bifocal \$158 - Trifocal \$50 - Lenticular		Not covered. Kaiser Permanente medical members may enroll in the EBMS \$500 vision plan.
Contact Lenses	\$100 per calendar year		

DENTAL COVERAGE

Monthly Premium Rates	Willamette Dental	Moda (ODS) Traditional Dental With Preventative First	Moda (ODS) Incentive Dental (Closed to new enrollment)
Employee Only	\$2.60	\$3.11	\$3.08
Employee + Spouse	\$5.20	\$6.22	\$6.15
Employee + Child(ren)	\$4.94	\$5.91	\$5.85
Employee + Family	\$7.54	\$9.02	\$8.92
Dental Services per member	Plan Pays:	Plan Pays:	Plan Pays:
Calendar Year Maximum per member	No Limit	\$1,500	\$1,000
Preventive (Class I): 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% - 1 st year* 80% - 2 nd year 90% - 3 rd year 100% - 4 th year
Basic (Class II): Fillings, Surgery, Endodontics, Periodontics	100% after co-pay \$65-\$150 co-pay per service; Fillings covered with office visit co-pay.	80%	*Must see dentist every year to increase and maintain benefit level
Major (Class III): Crowns and other cast restorations	100% after \$150 co-pay	60%	50%
Major (Class III): Dentures and Bridges	100% after co-pay Bridge: \$150 co-pay per tooth; Upper or Lower Denture: \$200 co-pay	60%	50%
Orthodontia, per member	100% after \$1,800 co-pay	50%: \$1,000 lifetime max	50%: \$1,000 lifetime max

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