

AFSCME Health Insurance Plan Options and Employee Premium Rates 2021

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 Must provide proof of other qualifying health insurance such as other employer health insurance through a spouse or parent 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. | \$0.00 \$0.00 \$0.00 \$0.00 *Pro-rated for part-time | \$98.71 \$286.26 \$286.26 \$286.26 *Pro-rated for part-time | \$36.86 \$73.71 \$70.02 \$106.88 *Pro-rated for part-time | | | \$32.98 \$65.96 \$62.66 \$95.63 *Pro-rated for part-time | | |
| Deductible & Out-of-Pocket Max | | 1 party | Family (2 party +) | 1 party | 2 party | Family | 1 party | 2 party | 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 | | 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 | | 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 | | 20% inpatient | | 20% inpatient | | 40% inpatient | | 20% inpatient | |
| Outpatient Rehabilitation (Physical, Speech, Occupational therapy) | | 20%; 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 (Note: Non-alternative care provided by a Naturopath is covered under office visits) | | 20% \$1,000 Combined Benefit Maximum per calendar year for Chiropractic and Acupuncture Care | | 40% \$1,000 Combined Benefit Maximum per calendar year for Chiropractic and Acupuncture Care | | \$10 per visit Deductible Waived \$1,000 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 | | \$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 | WellDyne HDHP | | WellDyne 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: | 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: | 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.

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 <small>*Pro-rated for part-time</small> | \$2.68 <small>*Pro-rated for part-time</small> | |
| 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 even 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 (Closed to new enrollment) |
|--|---|---|--|
| Employee Only | \$2.78 | \$3.11 | \$3.08 |
| Employee + Spouse | \$5.56 | \$6.22 | \$6.15 |
| Employee + Child(ren) | \$5.28 | \$5.91 | \$5.85 |
| Employee + Family | \$8.06 <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 | \$1,500 | \$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% <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%: \$1,000 lifetime max | 50%: \$1,000 lifetime max |

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