

PCEA 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> City HSA or HRAVEBA Contribution:	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 or Contribution		You Pay:		You Pay:			You Pay:			
Employee Only	\$225 *Pro-rated for part-time	\$25.14		\$36.86			\$32.98			
Employee + Spouse		\$50.28		\$73.71			\$65.96			
Employee + Child(ren)		\$47.77		\$70.02			\$62.66			
Employee + Family		\$72.91 *Pro-rated for part-time		\$106.88 *Pro-rated for part-time			\$95.63 *Pro-rated for part-time			
Deductible & Out-of-Pocket Max	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.	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%	40%	\$15 Primary / \$25 Specialist		
Lab & X-Ray Services			20%	40%	20%	40%	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	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 (Note: Non-alternative care provided by a Naturopath is covered under office visits)		20%	40%	\$10 per visit Deductible Waived		\$10 per visit Acupuncture, Chiropractic, Naturopathic				
		\$1,000 Combined Benefit Maximum per calendar year for Chiropractic and Acupuncture Care	\$1,000 Combined Benefit Maximum per calendar year for Chiropractic and Acupuncture Care	1,000 Combined Benefit Maximum per calendar year for Chiropractic and Acupuncture Care		\$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	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 \$250 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	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 \$250 every calendar year for any combination of routine eye exam, frames, lenses, or contacts	
Frames	\$40 once per 24 months		Not covered. Kaiser Permanente medical members may enroll in the EBMS \$250 vision plan
Lenses	\$89 - Single Vision \$125 - Bifocal \$158 - Trifocal \$50 - Lenticular		
Contact Lenses	\$100 per calendar year		

DENTAL COVERAGE

Monthly Premium Rates	Moda (ODS) Traditional Dental With Preventative First	Moda (ODS) Incentive Dental (Closed to new enrollment)
Employee Only	\$3.11	\$3.08
Employee + Spouse	\$6.22	\$6.15
Employee + Child(ren)	\$5.91	\$5.85
Employee + Family	\$9.02	\$8.92
Dental Services per member	Plan Pays:	Plan Pays:
Calendar Year Maximum per member	\$1,500	\$1,000
Preventive: Exams, X-Rays, Cleanings, Sealants, Fluoride	100% *Not included in calendar year maximum	70% - 1 st year 80% - 2 nd year 90% - 3 rd year 100% - 4 th year
Basic: Fillings, Surgery, Endodontics, Periodontics	80%	*Must see the dentist every year to increase and maintain benefit level
Major: Crowns and other cast restorations	60%	
Major: Dentures and Bridges		
Orthodontia per member	50%: \$1,000 lifetime max	50%: \$1,000 lifetime max

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