

SCABU Health Insurance Plan Options and Employee Premium Rates 2019

MEDICAL COVERAGE								
	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	You Pay:		You Pay:			You Pay:		
Employee Only	\$25.14		\$35.08			\$30.00		
Employee + Spouse	\$50.28		\$70.16			\$59.99		
Employee + Child(ren)	\$47.77		\$66.65			\$56.99		
Employee + Family	\$72.91		\$101.73			\$86.99		
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	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% \$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 / \$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 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 (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: 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 *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		
Orthodontia	100% after \$1,800 co-pay	50%: \$1,000 lifetime max	50%: \$1,000 lifetime max

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