SPEU CSO/Part-time .60FTE Employee Health Insurance Plan Options and Employee Premium Rates 2021

MEDICAL COVERAGE

	Opt-Out Plan *Have other coverage and want to save money for future health care expenses? Waive City coverage to receive contributions to your HRAVEBA*	**EBMS HDHP** *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 City contribution to your HRAVEBA*		***EBMS PPO*** *A traditional medical plan with higher monthly premiums, but lower deductible and annual out-of-pocket maximum*			***Kaiser Permanente*** *Want one-stop shopping for your medical needs? Choose this plan to receive coordinated care*		
Monthly Premium Rates and/or Contribution	**City HRAVEBA Contribution:**	**You pay:**	**City HRAVEBA Contribution:**	**You Pay:**			**You Pay:**		
Employee Only Employee + Spouse Employee + Child(ren) Employee + Family	$135.00 *Pro-rated 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 your HRAVEBA account.	$201.11 $402.21 $382.10 $583.21 *Pro-rated	$37.28 $170.82 $170.82 $170.82 *Pro-rated	$360.82 $655.63 $626.16 $920.97 *Pro-rated			$329.80 $593.61 $567.22 $831.04 *Pro-rated		
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 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% $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		Covered by vision plan	$15 per visit		

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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:**	**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.

VISION COVERAGE

Monthly Premium Rates	EBMS Traditional Vision	EBMS $500 Vision	Kaiser Permanente Vision
Employee Only Employee + Spouse Employee + Child(ren) Employee + Family	$3.90 $7.80 $7.41 $11.31 *Pro-rated	$7.37 $14.74 $14.00 $21.38 *Pro-rated	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 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	Moda (ODS) Traditional Dental With Preventative First	Moda (ODS) Incentive Dental
Employee Only Employee + Spouse Employee + Child(ren) Employee + Family	$24.86 $49.72 $47.23 $72.08 *Pro-rated	$24.61 $49.20 $46.74 $71.34 *Pro-rated
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% - 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	80%	
Major: Crowns and other cast restorations	60%	
Major: Dentures and Bridges		50%
Orthodontia	50%: $1,000 lifetime max	50%: $1,000 lifetime max

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