Health Insurance Plan Options and Employee Premium Rates SCABU 2023

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 an HSA or HRAVEBA*	**Cigna HDHP & HSA** *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)*		***Cigna PPO OAP*** *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 HSA or HRAVEBA Contribution:**	**You Pay:**	**City HSA Contribution:**	**You Pay:**			**You Pay:**		
Employee Only	$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	$136.39	$40.82			$34.42		
Employee + Spouse		$0.00	$395.51	$81.64			$68.84		
Employee + Child(ren)		$0.00	$395.51	$77.56			$65.40		
Employee + Family		$0.00 *Pro-rated for part-time	$395.51 *Pro-rated for part-time	$118.38 *Pro-rated for part-time			$99.81 *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 and testing		100% after deductible Maximum of 2 devices per 36 months		100% after deductible Maximum of 2 devices per 36 months			100% after deductible Maximum of 2 devices per 36 months		
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 Chiropractic Care, Massage Therapy, Acupuncture		20% after Deductible Chiropractic Care (includes massage therapy): limited to 20 visits per calendar year; Acupuncture limited to 12 visits per calendar year		$10 per visit Deductible Waived Chiropractic Care (includes massage therapy): limited to 20 visits per calendar year; Acupuncture limited to 12 visits per calendar year			Chiropractic Care $10 per visit; limited to 20 visits per calendar year Acupuncture $10 per visit; limited to 12 visits per calendar year Massage Therapy $25 per visit; limited to 12 visits 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	Cigna HDHP		Cigna PPO OAP			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 / $50 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%: $25 min / $100 max			$40 co-pay		
Non-Preferred	20%		30%: $45 min / $120 max			$80 co-pay		

Preferred drug list is subject to change without notice.

VISION COVERAGE

Monthly Premium Rates	**Cigna $500 Vision**	**Kaiser Permanente Vision**
Employee Only Employee + Spouse Employee + Child(ren) Employee + Family	$0.93 $1.85 $1.76 $2.68 *Pro-rated for part-time	Included in medical premium
Vision Services per member	**Plan Pays:**	**Plan Pays:**
Routine Eye Exam	100% allowed charges once per calendar year	Vision exams covered by medical plan
Vision Materials: Frames, Lenses, Contact Lenses	Up to $500 allowance every two calendar years for any combination of frames, lenses, or contacts	Vision materials not covered by Kaiser. Kaiser medical plan members may enroll in the Cigna $500 vision plan

Cigna preferred vision providers can be found online in the Cigna provider directory. Out-of-network vision providers may require you to submit a manual claim for reimbursement to Cigna. Your Frequency Period begins January 1 every year for exams and January 1 every other year for hardware.

DENTAL COVERAGE

Monthly Premium Rates	**Willamette Dental**	**Moda Traditional Dental With Preventative First**	**Moda Incentive Dental** *(Closed to new enrollment)*
Employee Only Employee + Spouse Employee + Child(ren) Employee + Family	$2.44 $4.88 $4.63 $7.07 *Pro-rated for part-time	$3.11 $6.22 $5.91 $9.02 *Pro-rated for part-time	$3.08 $6.15 $5.85 $8.92 *Pro-rated for part-time
Dental Services per member	**Plan Pays:**	**Plan Pays:**	**Plan Pays:**
Calendar Year Maximum per member	No Limit	$1,650	$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% - 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	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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