City of Dillingham

Based on Current Enrollment
Effective 7/1/2021.

		Medical	Dental	Vision	Total Monthly	Total Annual
Pref Choice HS $3,000 PPO	20%	**$63,418.07**	**$3,212.65**	**Included**	**$66,630.72**	**$799,568.64**
AMHT						
Fairweather $250 PPO	20%	$80,237.49	$3,293.50	Included	$83,530.99	$1,002,371.88
LeConte $500 PPO	20%	$76,968.63	$3,293.50	Included	$80,262.13	$963,145.56
Matanuska $1,500 PPO	20%	$71,640.75	$3,293.50	Included	$74,934.25	$899,211.00
Tustamena $3,000 PPO	30%	$64,988.46	$3,293.50	Included	$68,281.96	$819,383.52
Aurora $3,000 H S A	20%	$62,359.17	$3,293.50	Included	$65,652.67	$787,832.04
Columbia $5,000 H S A	30%	$56,050.65	$3,293.50	Included	$59,344.15	$712,129.80

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Medical Plan Options	CURRENT PLAN Premera Preferred Choice HS $3,000	Alaska Municipal Health Trust Plans Fairweather $250 PPO	LeConte $500 PPO	Matanuska $1,500 PPO	Tustamena $3,000 PPO
MEDICAL COST SHARES					
Individual Deductible (2x Family)	$3,000	$250	$500	$1,500	$3,000
Coinsurance	20%	20%	20%	20%	30%
Individual Out-of-Pocket Maximum (2x Family)	$6,000	$2,000	$3,500	$5,000	$8,000
Office Visit - Non Specialist and Specialist	Non-Specialist: $35 Specialist: $65	Non-Specialist: $25 Specialist: $50	Non-Specialist: $35 Specialist: $70	Non-Specialist: $40 Specialist: $80	Non-Specialist: $50 Specialist: $100
PREVENTIVE CARE & HEALTH EDUCATION					
Preventive Care (Immunizations, Preventative Office Visits, Health Education)	Covered in full	Covered in full	Covered in full	Covered in full	Covered in full
PROFESSIONAL CARE					
Professional Office Visit	Non-Specialist: $35 Specialist: $65	Non-Specialist: $25 Specialist: $50	Non-Specialist: $40 Specialist: $80	Non-Specialist: $40 Specialist: $80	Non-Specialist: $50 Specialist: $100
Teladoc	Covered in full	Covered in Full	Covered in full	Covered in full	Deductible, then 30%
DIAGNOSTIC SERVICES					
Preventive X-Ray and Labs - Including Mammogram & PAP	Covered in full	Covered in full	Covered in full	Covered in full	Covered in full
Professional X-Ray and Labs	20% Dedictible Waived	20% Dedictible Waived	20% Dedictible Waived	20% Dedictible Waived	Deductible, then 30%
FACILITY CARE					
Includes Inpatient, Skilled Nursing, and Outpatient Surgery Facilities	Deductible, then 20%	Deductible, then 20%	Deductible, then 20%	Deductible, then 20%	Deductible, then 30%
EMERGENCY CARE					
Emergency Care	$100, Deductible, then 20%	$300, Deductible, then 20%	$300, Deductible, then 20%	$300, Deductible, then 20%	$300, Deductible, then 30%
OTHER SERVICES					
Mental Health + Chemical Dependency Inpatient Facility Care	Deductible, then 20%	Deductible, then 20%	Deductible, then 20%	Deductible, then 20%	Deductible, then 30%
Mental Health + Chemical Dependency t Office Visit	Non-Specialist: $35	Non-Specialist: $25	Non-Specialist: $35	Non-Specialist: $40	Non-Specialist: $50
Maternity	Deductible, then 20%	Deductible, then 20%	Deductible, then 20%	Deductible, then 20%	Deductible, then 30%
Rehab Inpatient Facility 30 *days*	Deductible, then 20%	Deductible, then 20%	Deductible, then 20%	Deductible, then 20%	Deductible, then 30%
Rehab Outpatient Care - (Occupational Therapy, Physical Therapy, Massage Therapy, etc..) 45 *visits*	Specialist: $65	Specialist: $50	Specialist: $70	Specialist: $80	Specialist: $100

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		CURRENT PLAN	Alaska Municipal Health Trust Plans			
Medical Plan Options		**Premera Preferred Choice HS $3,000**	**Fairweather $250 PPO**	**LeConte $500 PPO**	**Matanuska $1,500 PPO**	**Tustamena $3,000 PPO**
ALTERNATIVE CARE						
Manipulations - Spinal and other (12 visits)		Non-Specialist: $35	Non-Specialist: $25	Non-Specialist: $35	Non-Specialist: $25	Non-Specialist: $50
Acupuncture (12 visits)		Non-Specialist: $35	Non-Specialist: $25	Non-Specialist: $35	Non-Specialist: $25	Non-Specialist: $50
Naturopathic		Non-Specialist: $35	Non-Specialist: $25	Non-Specialist: $35	Non-Specialist: $25	Non-Specialist: $50
PHARMACY						
Preventive Rx		Covered in Full	Covered in full	Covered in Full	Covered in Full	Covered in Full
Preferred Generic		$10	Deductible waived, then 10%	Deductible waived, then 10%	Deductible waived, then 10%	Deductible waived, then 10%
Preferred Brand		$25	Deductible waived, then 20%	Deductible waived, then 20%	Deductible waived, then 20%	Deductible waived, then 20%
Non-Preferred Drugs		$45	Deductible waived, then 30%	Deductible waived, then 30%	Deductible waived, then 30%	Deductible waived, then 30%
Preferred Specialty		30%	Deductible waived, then 10% with a $250 per script maximum	Deductible waived, then 10% with a $250 per script maximum	Deductible waived, then 10% with a $250 per script maximum	Deductible waived, then 10% with a $250 per script maximum
VISION						
ADULT VISION PLAN - MEMBERS 19+			***Note- Exam and hardware limits are separate**			
Vision Exams		10% Deductible Waived 1 Exam PCY Max benefit $350 PCY Frames every 2 yrs	Covered in Full up to $150 per Calendar Year	Covered in Full up to $150 per Calendar Year	Covered in Full up to $150 per Calendar Year	Covered in Full up to $150 per Calendar Year
Vision Hardware			Covered in Full up to $300 per Calendar Year	Covered in Full up to $300 per Calendar Year	Covered in Full up to $300 per Calendar Year	Covered in Full up to $300 per Calendar Year
PEDIATRIC VISION PLAN - MEMBERS UNDER 19						
Vision Exam		Covered in Full	Covered in Full	Covered in Full	Covered in Full	Covered in Full
Vision Hardware		1 Pair of Lenses or Frames Covered In Full per Calendar Year	1 Pair of Lenses or Frames Covered In Full per Calendar Year	1 Pair of Lenses or Frames Covered In Full per Calendar Year	1 Pair of Lenses or Frames Covered In Full per Calendar Year	1 Pair of Lenses or Frames Covered In Full per Calendar Year
Employee Only	27	$971.47	$1,202.06	$1,152.90	$1,073.27	$973.61
Employee + Spouse	6	$2,001.26	$2,704.63	$2,594.02	$2,414.85	$2,190.62
Employee + Child(ren)	3	$1,797.25	$2,103.61	$2,021.77	$1,878.23	$1,703.82
Family	7	$2,827.01	$3,606.18	$3,458.70	$3,219.81	$2,920.83
Monthly Medical Premium		**$63,418.07**	**$80,237.49**	**$76,968.63**	**$71,640.75**	**$64,988.46**
Annual Medical Premium		**$761,016.84**	**$962,849.88**	**$923,623.56**	**$859,689.00**	**$779,861.52**
Percentage Change From Current Medical			**27%**	**21%**	**13%**	**2%**
Annual Dollar Change From Current Medical			**$201,833.04**	**$162,606.72**	**$98,672.16**	**$18,844.68**

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Medical Plan Options	CURRENT PLAN Premera Preferred Choice HS $3,000	Aurora $3,000 HSA	Columbia $5,000 HSA
MEDICAL COST SHARES			
Individual Deductible (2x Family)	$3,000	$3,000	$5,000
Coinsurance	20%	20%	30%
Individual Out-of-Pocket Maximum (2x Family)	$6,000	$6,000	$7,000
Office Visit - Non Specialist and Specialist	Non-Specialist: $35 Specialist: $65	Deductible, then 20%	Deductible, then 30%
PREVENTIVE CARE & HEALTH EDUCATION			
Preventive Care (Immunizations, Preventative Office Visits, Health Education)	Covered in full	Covered in full	Covered in full
PROFESSIONAL CARE			
Professional Office Visit	Non-Specialist: $35 Specialist: $65	Deductible, then 20%	Deductible, then 30%
Teladoc	Covered in full	Deductible, then 20%	Deductible, then 30%
DIAGNOSTIC SERVICES			
Preventive X-Ray and Labs - Including Mammogram & PAP	Covered in full	Covered in full	Covered in full
Professional X-Ray and Labs	20% Dedictible Waived	Deductible, then 20%	Deductible, then 30%
FACILITY CARE			
Includes Inpatient, Skilled Nursing, and Outpatient Surgery Facilities	Deductible, then 20%	Deductible, then 20%	Deductible, then 30%
EMERGENCY CARE			
Emergency Care	$100, Deductible, then 20%	Deductible, then 20%	Deductible, then 30%
OTHER SERVICES			
Mental Health + Chemical Dependency Inpatient Facility Care	Deductible, then 20%	Deductible, then 20%	Deductible, then 30%
Mental Health + Chemical Dependency t Office Visit	Non-Specialist: $35	Deductible, then 20%	Deductible, then 30%
Maternity	Deductible, then 20%	Deductible, then 20%	Deductible, then 30%
Rehab Inpatient Facility 30 *days*	Deductible, then 20%	Deductible, then 20%	Deductible, then 30%
Rehab Outpatient Care - (Occupational Therapy, Physical Therapy, Massage Therapy, etc..) 45 *visits*	Specialist: $65	Deductible, then 20%	Deductible, then 30%

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Medical Plan Options		CURRENT PLAN Premera Preferred Choice HS $3,000	Aurora $3,000 HSA	Columbia $5,000 HSA
ALTERNATIVE CARE				
Manipulations - Spinal and other (12 visits)		Non-Specialist: $35	Deductible, then 20%	Deductible, then 30%
Acupuncture (12 visits)		Non-Specialist: $35	Deductible, then 20%	Deductible, then 30%
Naturopathic		Non-Specialist: $35	Deductible, then 20%	Deductible, then 30%
PHARMACY				
Preventive Rx		Covered in Full	Covered in Full	Covered in Full
Preferred Generic		$10	Deductible, then 20%	Deductible, then 30%
Preferred Brand		$25	Deductible, then 20%	Deductible, then 30%
Non-Preferred Drugs		$45	Deductible, then 20%	Deductible, then 30%
Preferred Specialty		30%	Deductible, then 20%	Deductible, then 30%
VISION				
ADULT VISION PLAN - MEMBERS 19+				
Vision Exams		10% Deductible Waived 1 Exam PCY Max benefit $350 PCY Frames every 2 yrs	Covered in Full up to $150 per Calendar Year	Covered in Full up to $150 per Calendar Year
Vision Hardware			Covered in Full up to $300 per Calendar Year	Covered in Full up to $300 per Calendar Year
PEDIATRIC VISION PLAN - MEMBERS UNDER 19				
Vision Exam		Covered in Full	Covered in Full	Covered in Full
Vision Hardware		1 Pair of Lenses or Frames Covered In Full per Calendar Year	1 Pair of Lenses or Frames Covered In Full per Calendar Year	1 Pair of Lenses or Frames Covered In Full per Calendar Year
Employee Only	27	$971.47	$934.22	$839.71
Employee + Spouse	6	$2,001.26	$2,101.99	$1,889.35
Employee + Child(ren)	3	$1,797.25	$1,634.89	$1,469.49
Family	7	$2,827.01	$2,802.66	$2,519.13
Monthly Medical Premium		**$63,418.07**	**$62,359.17**	**$56,050.65**
Annual Medical Premium		**$761,016.84**	**$748,310.04**	**$672,607.80**
Percentage Change From Current Medical			**-2%**	**-12%**
Annual Dollar Change From Current Medical			**-$12,706.80**	**-$88,409.04**

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Family Dental Options				
		Premera Dopt $50-0%/20%/50%/$1500 BER	AMHT Foraker Base Plan	AMHT Denali Buy Up Plan
Deductible *(only applies to Basic and Major)*		$50 Indiv / $150 Family	$50 Indiv / $150 Family	$50 Indiv / $150 Family
Diagnostic & Preventive (Class I) *(e.g. cleanings, oral exams, bitewing x-rays)*		Covered in Full	Covered in Full	Covered in Full
Basic (Class II) *(e.g. fillings, periodontal maintenance, simple extractions)*		Deductible, then 20%	Deductible, then 20%	Deductible, then 20%
Major (Class III) *(e.g. crowns, dentures (Optima only), bridges (Optima only))*		Deductible, then 50%	Deductible, then 50%	Deductible, then 50%
Maximum Allowance		$1,500	$1,500	$2,000
Enhanced		Periodontal/ Endodontic in Major	Periodontal/ Endodontic in Major	Periodontal/ Endodontic in Basic
Preventive Waived (Class I) from Max Allowance		No	No	Yes
Orthodontia Coverage		No	No	Yes - $1,500 Lifetime
Employee Only	27	$46.16	$47.32	$52.60
Employee + Spouse	6	$99.24	$101.74	$112.86
Employee + Child(ren)	3	$101.55	$104.10	$128.92
Family	7	$152.32	$156.16	$186.63
Monthly Dental Premium		**$3,212.65**	**$3,293.50**	**$3,790.53**
Annual Dental Premium		**$38,551.80**	**$39,522.00**	**$45,486.36**
Percentage Change From Current Dental			3%	18%
Annual Dollar Change From Current			$970.20	$6,934.56