City of Homer
Medical/Vision Plan Proposal
Effective Date: January 1, 2014

PREMERA BLUE CROSS

Benefits	In Network	Out of Network
Lifetime/Annual Max Maximum	Unlimited	
Deductible		
Individual	$100	$300
Family	$300	$900
Coinsurance (Plan Pays / Member Pays)	90 / 10%	40/60%: Hospital/CD Facility 90/10%: ARP/Other Facilities & Other Professionals
Out of Pocket Max		
Individual *(includes deductible)*	$500	N/A
Family *(includes deductible)*	$1,500	N/A
Office Visits (including Urgent Care)	90% after deductible	90% after deductible
Diagnostic Lab & X-Ray	90% after deductible	40% after deductible: Hospital/CD Facility 90% after deductible: ARP/Other Facilities & Other Professionals
Preventive Care		
Preventive Care Office Visits	Covered in full	Covered in full
Preventive Care DX&L	Covered in full	40% after deductible: Hospital/CD Facility 90% after deductible: ARP/Other Facilities & Other Professionals
Hospital Benefits		
Inpatient	90% after deductible - Preferred; 60% after deductible - Participating	40% after deductible: Hospital/CD Facility 90% after deductible: ARP/other Facilities & Other Professionals
Outpatient Surgery	90% after deductible - Preferred; 60% after deductible - Participating	40% after deductible: Hospital/CD Facility 90% after deductible: ARP/other Facilities & Other Professionals
Emergency Room (copay waived if admitted to inpatient facility)	90% after deductible	
Prescription Drugs		
Retail *(90 day supply)*	$5/$10	$5/$10
Mail Order *(90 day supply)*	$10/$30	Not Covered
Mental Health		
Inpatient (unlimited days)	90% after deductible - Preferred	40% after deductible: Hospital/CD Facility 90% after deductible: ARP/other Facilities & Other Professionals
Outpatient (unlimited visits)	90% after deductible	90% after deductible
Manipulations (Spinal and other) (24 visits PCY)	90% after deductible	90% after deductible
Vision Exam (1 PCY; $350 PCY, shared with Vision Hardware)	AK Mandate 90%	90% (deductible waived)
Vision Hardware (1 pair of frames every 2 years, combined $90 dollars retail max. Contacts $170 PCY max; Vision Exam/Test and Hardware annual max $350)	Covered in full	Covered in full

Rates		Premera Proposal #1
Employee	25	$1,281.44
Employee Spouse	22	$2,947.31
Employee Child(ren)	14	$2,942.19
Employee Spouse Child(ren)	40	$4,677.25
Estimated Monthly Premium	101	$325,157.48
Estimated Annual Premium		$3,901,889.76

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MERCER

City of Homer
Medical/Vision Plan Proposal
Effective Date: January 1, 2014

PREMERA BLUE CROSS

Benefits	In Network	Out of Network
Lifetime/Annual Max Maximum	**Unlimited**	
Deductible		
Individual	**$500**	**$1,500**
Family	**$1,500**	**$4,500**
Coinsurance (Plan Pays / Member Pays)	**80 / 20%**	**40/60%: Hospital/CD Facility** **80/20%: ARP/Other Facilities & Other Professionals**
Out of Pocket Max		
Individual *(includes deductible)*	**$2,000**	**N/A**
Family *(includes deductible)*	**$6,000**	**N/A**
Office Visits (including Urgent Care)	**80% after deductible**	**80% after deductible**
Diagnostic Lab & X-Ray	**80% after deductible**	**40% after deductible: Hospital/CD Facility** **80% after deductible: ARP/Other Facilities & Other Professionals**
Preventive Care		
Preventive Care Office Visits	**Covered in full**	**Covered in full**
Preventive Care DX&L	**Covered in full**	**40% after deductible: Hospital/CD Facility** **80% after deductible: ARP/Other Facilities & Other Professionals**
Hospital Benefits		
Inpatient	**80% after deductible - Preferred;** **60% after deductible - Participating**	**40% after deductible: Hospital/CD Facility** **80% after deductible: ARP/Other Facilities & Other Professionals**
Outpatient Surgery	**80% after deductible - Preferred;** **60% after deductible - Participating**	**40% after deductible: Hospital/CD Facility** **80% after deductible: ARP/Other Facilities & Other Professionals**
Emergency Room (copay waived if admitted to inpatient facility)	**80% after deductible**	
Prescription Drugs		
Retail *(90 day supply)*	**$5/$10**	**$5/$10**
Mail Order *(90 day supply)*	**$10/$30**	**Not Covered**
Mental Health		
Inpatient (unlimited days)	**80% after deductible - Preferred**	**40% after deductible: Hospital/CD Facility** **80% after deductible: ARP/Other Facilities & Other Professionals**
Outpatient (unlimited visits)	**80% after deductible**	**80% after deductible**
Manipulations (Spinal and other) (24 visits PCY)	**80% after deductible**	**80% after deductible**
Vision Exam (1 PCY; $350 PCY, shared with Vision Hardware)	**AK Mandate 90%**	**90% (deductible waived)**
Vision Hardware (1 pair of frames every 2 years, combined $90 dollars retail max. Contacts $170 PCY max; Vision Exam/Test and Hardware annual max $350)	**Covered in full**	**Covered in full**

Rates		Premera Proposal #2
Employee	**25**	**$1,119.82**
Employee Spouse	**22**	**$2,575.58**
Employee Child(ren)	**14**	**$2,571.11**
Employee Spouse Child(ren)	**40**	**$4,087.34**
Estimated Monthly Premium	**101**	**$284,147.40**
Estimated Annual Premium		**$3,409,768.80**

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MERCER

City of Homer
Medical/Vision Plan Proposal
Effective Date: January 1, 2014

PREMERA BLUE CROSS

Benefits	In Network	Out of Network
Lifetime/Annual Max Maximum	**Unlimited**	
Deductible		
Individual	**$1,000**	**$3,000**
Family	**$3,000**	**$9,000**
Coinsurance (Plan Pays / Member Pays)	**70 / 30%**	**40/60%: Hospital/CD Facility** **70/30%: ARP/Other Facilities & Other Professionals**
Out of Pocket Max		
Individual *(includes deductible)*	**$2,000**	**N/A**
Family *(includes deductible)*	**$6,000**	**N/A**
Office Visits (including Urgent Care)	**70% after deductible**	**70% after deductible**
Diagnostic Lab & X-Ray	**70% after deductible**	**40% after deductible: Hospital/CD Facility** **70% after deductible: ARP/Other Facilities & Other Professionals**
Preventive Care		
Preventive Care Office Visits	**Covered in full**	**Covered in full**
Preventive Care DX&L	**Covered in full**	**40% after deductible: Hospital/CD Facility** **70% after deductible: ARP/Other Facilities & Other Professionals**
Hospital Benefits		
Inpatient	**70% after deductible - Preferred;** **60% after deductible - Participating**	**40% after deductible: Hospital/CD Facility** **70% after deductible: ARP/Other Facilities & Other Professionals**
Outpatient Surgery	**70% after deductible - Preferred;** **60% after deductible - Participating**	**40% after deductible: Hospital/CD Facility** **70% after deductible: ARP/Other Facilities & Other Professionals**
Emergency Room (copay waived if admitted to inpatient facility)	**70% after deductible**	
Prescription Drugs		
Retail *(90 day supply)*	**$5/$10**	**$5/$10**
Mail Order *(90 day supply)*	**$10/$30**	**Not Covered**
Mental Health		
Inpatient (unlimited days)	**70% after deductible - Preferred**	**40% after deductible: Hospital/CD Facility** **70% after deductible: ARP/Other Facilities & Other Professionals**
Outpatient (unlimited visits)	**70% after deductible**	**70% after deductible**
Manipulations (Spinal and other) (24 visits PCY)	**70% after deductible**	**70% after deductible**
Vision Exam (1 PCY; $350 PCY, shared with Vision Hardware)	**AK Mandate 90%**	**90% (deductible waived)**
Vision Hardware (1 pair of frames every 2 years, combined $90 dollars retail max. Contacts $170 PCY max; Vision Exam/Test and Hardware annual max $350)	**Covered in full**	**Covered in full**

Rates		Premera Proposal #3
Employee	**25**	**$1,034.92**
Employee Spouse	**22**	**$2,380.32**
Employee Child(ren)	**14**	**$2,376.18**
Employee Spouse Child(ren)	**40**	**$3,777.45**
Estimated Monthly Premium	**101**	**$262,604.56**
Estimated Annual Premium		**$3,151,254.72**

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City of Homer
Medical/Vision Plan Proposal
Effective Date: January 1, 2014

PREMERA BLUE CROSS

Benefits	In Network	Out of Network
Lifetime/Annual Max Maximum	**Unlimited**	
Deductible		
Individual	**$1,250**	
Family (aggregate deductible)	**$2,500**	
Coinsurance (Plan Pays / Member Pays)	**80 / 20%**	**40/60%: Hospital/CD Facility** **80/20%: ARP/Other Facilities & Other Professionals**
Out of Pocket Max		
Individual *(includes deductible)*	**$5,000**	**N/A**
Family *(includes aggregate deductible)*	**$10,000**	**N/A**
Office Visits (including Urgent Care)	**80% after deductible**	**80% after deductible**
Diagnostic Lab & X-Ray	**80% after deductible**	**40% after deductible: Hospital/CD Facility** **80% after deductible: ARP/Other Facilities & Other Professionals**
Preventive Care		
Preventive Care Office Visits	**Covered in full**	**Covered in full**
Preventive Care DX&L	**Covered in full**	**40% after deductible: Hospital/CD Facility** **80% after deductible: ARP/Other Facilities & Other Professionals**
Hospital Benefits		
Inpatient	**80% after deductible -Preferred;** **60% after deductible - Participating**	**40% after deductible: Hospital/CD Facility** **80% after deductible: ARP/Other Facilities & Other Professionals**
Outpatient Surgery	**80% after deductible - Preferred;** **60% after deductible - Participating**	**40% after deductible: Hospital/CD Facility** **80% after deductible: ARP/Other Facilities & Other Professionals**
Emergency Room (copay waived if admitted to inpatient facility)	**80% after deductible**	
Prescription Drugs		
Retail *(90 day supply)*	**80% after deductible**	**80% after deductible**
Mail Order *(90 day supply)*	**80% after deductible**	**Not Covered**
Mental Health		
Inpatient (unlimited days)	**80% after deductible - Preferred**	**40% after deductible: Hospital/CD Facility** **80% after deductible: ARP/Other Facilities & Other Professionals**
Outpatient (unlimited visits)	**80% after deductible**	**80% after deductible**
Manipulations (Spinal and other) (12 visits PCY)	**80% after deductible**	**80% after deductible**
Vision Exam (1 PCY; $350 PCY, shared with Vision Hardware)	**AK Mandate 90%**	**90% (deductible waived)**
Vision Hardware (1 pair of frames every 2 years, combined $90 dollars retail max. Contacts $170 PCY max; Vision Exam/Test and Hardware annual max $350)	**Covered in full**	**Covered in full**

Rates		Premera Proposal #4
Employee	**25**	**$812.12**
Employee Spouse	**22**	**$1,867.87**
Employee Child(ren)	**14**	**$1,864.63**
Employee Spouse Child(ren)	**40**	**$2,964.24**
Estimated Monthly Premium	**101**	**$206,070.56**
Estimated Annual Premium		**$2,472,846.72**

This is a summary of benefits. This is not a contract.

MERCER

City of Homer
Medical/Vision Plan Proposal
Effective Date: January 1, 2014

aetna

Benefits	In Network	Out of Network
Lifetime/Annual Max Maximum	**Unlimited**	
Deductible		
Individual	**$100**	**$100**
Family	**$300**	**$3,000**
Coinsurance (Plan Pays / Member Pays)	**90 / 10%**	**70 / 30%**
Out of Pocket Max		
Individual *(includes deductible)*	**$700**	**$700**
Family *(includes deductible)*	**$1,400**	**$1,400**
Office Visits	**Primary: 100% after deductible** **Specialists: 90% after deductible**	**70% after deductible**
Diagnostic Lab & X-Ray	**90% after deductible**	**70% after deductible**
Hospital Benefits		
Inpatient	**90% after deductible**	**70% after deductible**
Outpatient Surgery	**90% after deductible**	**70% after deductible**
Emergency Room (copay waived if admitted)	**90% after deductible**	
Prescription Drugs		
Retail *(90 day supply)*	**$5 / $15**	**70% after deductible**
Mail Order *(90 day supply)*	**$10 / $30**	**Not Covered**
Vision Exam	**1 exam every 12 months**	
Vision Hardware	**$200 allowance every 24 months**	

Rates		Aetna Proposal
Employee	**25**	**$1,070.95**
Employee Spouse	**22**	**$2,356.09**
Employee Child(ren)	**14**	**$1,927.71**
Employee Spouse Child(ren)	**40**	**$3,319.95**
Estimated Monthly Premium	**101**	**$238,393.67**
Estimated Annual Premium		**$2,860,724.04**

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ALASKA POLITICAL SUBDIVISIONS
Medical Plan Comparison Chart
Effective July 1, 2013

Eligibility: Full-Time Permanent Employees (30+ hours) on 31st day of pay; Part-Time Permanent Employees (15-30 hours) who elect coverage on 31st day of pay; Elected Officials who receive a salary - effective date when sworn into office.
Eligible Dependents: Spouse or Domestic Partner (same sex) and Children up to age 26; Newborns automatically covered first 60 days (legislative).

Plan Provision	Plan I	Plan II	Plan III	Plan IV HDHP
Calendar Year Deductible	$250/$750	$500/$1,500	$750/$2,250	$2,000 Individual Plan $4,000 Family Plan
Office Visit Deductible (In addition to calendar year deductible)	$10/Visit	$10/Visit	$10/Visit	N/A
Out-of-Network Hospital Admission Deductible (Additional)	$500 per admission	$500 per admission	$500 per admission	$500 per admission
Deductible Carryover	Does not apply			N/A
Coinsurance - In-network	90%	80%	80%	80%
Coinsurance - Out of network	70%	60%	60%	60%
Emergency Room	90%, 50% for non-emergency use	80%, 50% for non-emergency use	80%, 50% for non-emergency use	80%, 50% for non-emergency use
In-Network Out of Pocket Limit	$500 (Doesn't include deductible)	$1000 (Doesn't include deductible)	$2000 (Doesn't include deductible)	$3,000 Individual Plan $6,000 Family Plan
Out-of-Network Out of Pocket Limit - Additional	N/A	N/A	N/A	$1,000 Individual Plan $2,000 Family Plan
Prescription Drugs - Retail *(30 day max supply)* ***Medications obtained from a non-network pharmacy*** are reimbursable at 80% after the separate pharmacy deductible (Plans I, II and III). For Plan IV, combined medical and pharmacy deductible must be met before reimbursement applies. ***Member must pay up front.***	After separate $50/$150 annual deductible, the member's coinsurance is: 1) Generics - 0% 2) Brand Formulary - 20%* 3) Brand Non-Formulary 30% * * Minimum and Maximum copays apply	After separate $50/$150 annual deductible, the member's coinsurance is: 1) Generics - 0% 2) Brand Formulary - 20%* 3) Brand Non-Formulary 30% * * Minimum and Maximum copays apply	After separate $50/$150 annual deductible, the member's coinsurance is: 1) Generics - 0% 2) Brand Formulary - 20%* 3) Brand Non-Formulary 30% * * Minimum and Maximum copays apply	After deductible, the following copayments apply: 1) Generics – $10 2) Brand Formulary - $20 3) Brand Non-Formulary - $35
Mail Order Pharmacy *(90 day max supply)*	Generics - $10 copay Brands - $30 copay	Generics - $10 copay Brands - $30 copay	Generics - $10 copay Brands - $30 copay	After deductible, the following copayments apply: 1) Generics – $20 2) Brand Formulary - $40 3) Brand Non-Formulary - $60
Mandatory Generics	Applies	Applies	Applies	Applies

This chart is meant to be a summary only of the main features of the plan of benefits. Please refer to the Aetna Plan booklet certificates for the State of Alaska Political Subdivisions, including summary of changes, for additional details.

ALASKA POLITICAL SUBDIVISIONS
Medical Plan Comparison Chart
Effective July 1, 2013

Plan Provision	Plan I	Plan II	Plan III	Plan IV HDHP
Preventive Care including cancer screenings (Paps, PSA, Mammograms and Colorectal Cancer Screening)	100% coverage for adult/well child care No deductible	100% coverage for adult/well child care No deductible	100% coverage for adult/well child care No deductible	100% coverage for adult/well child care No deductible
Spinal Disorders	Subject to Medical Necessity			25 visits
Durable Medical Equipment	Unlimited	Unlimited	Unlimited	$10,000 maximum per year
Skilled Nursing - Convalescent Facility	120 days per year	120 days per year	120 days per year	120 days per year
Home Health Care	Unlimited	Unlimited	Unlimited	60 Visits per year
Private Duty Nursing	Unlimited	Unlimited	Unlimited	70 8-hr shifts per year
Hospice	90% after deductible, no maximums	80% after deductible, no maximums	80% after deductible, no maximums	80% after deductible, no maximums
Mental Health or Chemical Dependency Treatment – Inpatient	90% after deductible	80% after deductible	80% after deductible	80% after deductible
Mental Health or Chemical Dependency Treatment – Outpatient	90% after deductible	80% after deductible	80% after deductible	80% after deductible
Pre-Existing Conditions	$1000 first 12 months *(Does not apply to children under the age of 19)*			

This chart is meant to be a summary only of the main features of the plan of benefits. Please refer to the Aetna Plan booklet certificates for the State of Alaska Political Subdivisions, including summary of changes, for additional details.

POLITICAL SUBDIVISION HEALTH AND LIFE PREMIUMS - Effective July 1, 2013

Plan is on Calendar Year, Premiums set on Fiscal year

Traditional Plans

	Medical Premium		DVA Premium		Total Monthly Premium	Combined Family Health Premium	Basic Life	Combined Family Life Premium
			Dependent DVA Optional			*Includes Medical & DVA for all Covered Family*		*Includes Life for all Covered Family*
Plan I- Suffix 31								
$250 ded, 90% coinsurance, $500 out of pocket limit								
Employee	$ 1,523.23	+	*Included*	=	$ 1,523.23		$0.59	
Child/Children	$ 1,216.30	+	$ 85.00	=	$ 1,301.30	$ 2,824.53	$0.09	$0.68
Spouse	$ 1,790.22	+	$ 81.00	=	$ 1,871.22	$ 3,394.45	$0.19	$0.78
Spouse and Children	$ 3,024.92	+	$ 165.75	=	$ 3,190.67	$ 4,713.90	$0.28	$0.87
Plan II - Suffix 32								
$500 ded, 80% coinsurance, $1000 out of pocket limit								
Employee	$ 1,157.35	+	*Included*	=	$ 1,157.35		$0.59	
Child/Children	$ 905.00	+	$ 85.00	=	$ 990.00	$ 2,147.35	$0.09	$0.68
Spouse	$ 1,356.24	+	$ 81.00	=	$ 1,437.24	$ 2,594.59	$0.19	$0.78
Spouse and Children	$ 2,260.77	+	$ 165.75	=	$ 2,426.52	$ 3,583.87	$0.28	$0.87
Plan III - Suffix 33								
$750 ded, 80% coinsurance, $2000 out of pocket limit								
Employee	$ 915.39	+	*Included*	=	$ 915.39		$0.59	
Child/Children	$ 752.88	+	$ 85.00	=	$ 837.88	$ 1,753.27	$0.09	$0.68
Spouse	$ 1,123.99	+	$ 81.00	=	$ 1,204.99	$ 2,120.38	$0.19	$0.78
Spouse and Children	$ 1,876.78	+	$ 165.75	=	$ 2,042.53	$ 2,957.92	$0.28	$0.87

Employee coverage is mandatory for all permanent employees and includes medical and dental-vision-audio, Basic Life and AD&D coverage.

Medical/Life insurance is optional for dependents and may be selected with or without the DVA portion of the package. The DVA coverage **CANNOT** be selected without the medical/life

Health insurance premiums are paid directly to Aetna. Life insurance premiums are paid directly to Unum

You must pay life insurance premiums on all employees for whom you pay health premiums.

POLITICAL SUBDIVISION HEALTH AND LIFE PREMIUMS - Effective July 1, 2013

Plan is on Calendar Year, Premiums set on Fiscal year

High Deductible Health Plan Option **Plan IV - Suffix 34** *Ind: $2000 ded, 80% coinsurance, $3000 out of pocket limit* *Fam: $4000 ded, 80% coinsurance, $6000 out of pocket limit*	Medical Premium		DVA Premium *Dependent DVA Optional*		Total Monthly Premium	Combined Family Health Premium *Includes Medical & DVA for all Covered Family*	Basic Life	Combined Family Life Premium *Includes Life for all Covered Family*
Employee	$ 642.01	+	*Included*	=	**$ 642.01**		**$0.59**	
Child/Children	$ 503.15	+	$ 85.00	=	$ 588.15	**$ 1,230.16**	$0.09	**$0.68**
Spouse	$ 744.23	+	$ 81.00	=	$ 825.23	**$ 1,467.24**	$0.19	**$0.78**
Spouse and Children	$ 1,247.28	+	$ 165.75	=	$ 1,413.03	**$ 2,055.04**	$0.28	**$0.87**

Employee coverage is mandatory for all permanent employees and includes medical and dental-vision-audio, Basic Life and AD&D coverage.

Medical/Life insurance is optional for dependents and may be selected with or without the DVA portion of the package. The DVA coverage **CANNOT** be selected without the medical/life

Health insurance premiums are paid directly to Aetna. Life insurance premiums are paid directly to Unum

You must pay life insurance premiums on all employees for whom you pay health premiums.

City of Homer
Dental Plan Proposal
Effective Date: January 1, 2014

Benefits	In / Out of Network
Annual Maximum	**$1,500 PCY**
Deductible	
Individual	**$50**
Family	**$150**
Preventive Services	**100%**
Basic Services	**80%**
Major Services	**50%**
Orthodontia Benefit (Lifetime)	**$1,000**

Rates		Premera
Employee	**25**	**$62.87**
Employee + Spouse	**22**	**$135.17**
Employee + Child(ren)	**14**	**$152.31**
Employee + Family	**40**	**$221.47**
Estimated Monthly Premium	**101**	**$15,536.63**
Estimated Annual Premium		**$186,439.56**

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City of Homer
Dental Plan Proposal
Effective Date: January 1, 2014

aetna

Benefits	In / Out of Network
Annual Maximum	$1,500 PCY
Deductible	
Individual	$50
Family	$150
Preventive Services	80%
Basic Services	80%
Major Services	60%
Orthodontia Benefit (Lifetime)	70% to $750

Rates		Aetna
Employee	25	$54.41
Employee + Spouse	22	$105.30
Employee + Child(ren)	14	$120.83
Employee + Family	40	$171.72
Estimated Monthly Premium	101	$12,237.27
Estimated Annual Premium		$146,847.24

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