

# 2012 MARION COUNTY HEALTH PLANS SUMMARY

## For MCEA, MCJEA, FOPPO & ONA Represented Employees, Unit 12, Management & Housing Authority

This is a summary of benefits only. For a complete description of benefits refer to the carrier's benefit summary located on the Marion County website at <http://www.co.marion.or.us/BS/Risk/benefits.htm> or contact the carrier: Kaiser Permanente (in Salem) at 503-361-5400 or ODS at 1-888-217-2363. Claims will be paid as per the carrier's information and contract.

| MEDICAL SERVICES   | ODS PPO with HSA  |                                   | ODS Traditional PPO  |  | Kaiser HMO   |
|--|---|-----------------------------------|--|--|--|
|  | In-Network (ODS Network)  | Out-of-Network (Any Provider)     | In-Network (ODS Network)   | Out-of-Network (Any Provider)                        | Kaiser Facilities Only   |
| <b>Annual Deductible</b><br>Deductible must be met before benefits are paid by carrier.  | \$1,200 Employee Only / \$2,400 Family<br><i>Marion County contributes a pro-rated amount to the HSA based on the medical plan effective date.</i><br>Family deductible is combined and can be met by 1 family member |                                   | \$500 per Person<br>\$1,500 Family Maximum   |  | None   |
| <b>Annual Out-of-Pocket Maximum</b>  | \$3,800 Single<br>\$7,600 Family  | \$7,600 Single<br>\$15,200 Family | \$5,000 / Person<br>\$15,000 / Family  | \$10,000 / Person<br>\$30,000 / Family               | \$600 / Person<br>\$1,200 Family Maximum   |
| <b>Annual Benefit Max.</b>   | \$2,000,000   |                                   | \$2,000,000  |  | Unlimited  |
|  | <b>After Deductible Employee Pays</b>   |                                   | <b>After Deductible Employee Pays</b>  |  | <b>Employee Pays</b>   |
| <b>Preventative Services</b><br>Well Baby Visits to age 2<br>Standard Immunizations<br>Men's Annual PRE/PSA<br>Women's Annual Exams  | Paid in Full<br>**unless diagnostic care is included on same visit  | 40%                               | Paid in Full<br>**unless diagnostic care is included on same visit   | 50%<br>(Only women's annual & men's PRE are covered) | \$0 for well baby age 0-2<br>\$0 routine immunizations<br>\$0 co-pay for preventive men & women exams                |
| <b>Office Visits</b>   | 20%   | 40%                               | 25%  | 50%  | <b>\$15 co-pay</b>   |
| <b>Specialist Visit</b>  | 20%   | 40%                               | <b>\$35 co-pay</b>   | 50%  | <b>\$15 co-pay</b>   |
| <b>Lab &amp; X-Ray; Urgent Care Visits</b>   | 20%   | 40%                               | 25%, deductible waived   | 50%  | \$0 for Lab & X-Ray<br><b>Urgent Care \$35 co-pay</b>  |
| <b>MRI/CAT/PET/Sleep Study services</b>  | 20%   | 40%                               | <b>\$100 co-pay, then 25%</b>  | 50%  | Imaging \$0 / <b>Sleep Study visit \$35 co-pay</b>   |
| <b>Emergency Room Facility</b>   | 20%   | 40%                               | \$50 co-pay, waived if admitted, then 25%<br>(Deductible Waived)   |  | <b>\$100 co-pay, waived if admitted</b>  |
| <b>Ambulance</b>   | 20%<br>(\$5,000 annual maximum)   |                                   | 25%<br>(\$5,000 annual maximum)  |  | <b>No Charge</b>   |
| <b>Hospital Semi-private Room &amp; Board</b>  | 20%   | 40%                               | \$100 co-pay *<br>then 25%   | 50%  | <b>\$50 per day up to \$250 per admittance</b>   |
| <b>Inpatient Surgery</b>   | 20%   | 40%                               | 25%  | 50%  | Paid in Full   |
| <b>Outpatient Services</b>   | 20%   | 40%                               | 25%  | 50%  | <b>\$15 co-pay</b>   |
| <b>Maternity Care</b>  | 20%   | 40%                               | 25%  | 50%  | \$0 for Prenatal care & 1 <sup>st</sup> postpartum care  |
| <b>Skilled Nursing Facility Care</b>   | 20%   | 40%                               | 25%  | 50%  | Paid in full up to 100 days per year   |
| <b>Durable Medical Equip</b>   | 20% (\$5000/yr)   | 40%                               | 25% (\$5000/yr)  | 50%  | 20%  |
| <b>Prescriptions (Rx)</b>  | You pay full cost up front for Rx even after meeting the deductible. Once your deductible is met, 20% (ODS will reimburse you at 80%)   |                                   | Value Rx: \$2 co-pay*<br><b>Generic: \$10 co-pay*</b><br><b>Preferred: \$30 co-pay*</b><br>Non-Preferred: 50% co-pay*<br>(Mail order available.) |  | \$10 co-pay for Generic<br>\$20 co-pay for Brand for 30-day supply<br>Mail order: \$20/\$40 co-pay for 90-day supply |
| *On the ODS Traditional PPO Plan: Co-pays do not apply to the annual deductible. **On both ODS plans: In-network routine diagnostic x-ray and lab work related to a periodic health exam are subject to the deductible; after meeting your deductible you are responsible for the coinsurance. Expenses applied toward annual deductible do not apply to the annual out-of-pocket maximum. |   |                                   |  |  |  |

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| <b>ALTERNATIVE CARE</b><br>Chiropractic, Acupuncture & Naturopath | 20%<br>(\$1,500 combined annual maximum)<br>Subject to deductible | 25%<br>(\$1,500 combined annual maximum)<br>Deductible Waived | \$10 co-pay; must use CHP Network / \$25 co-pay for Massage Therapy 12 visits/ yr \$1,000 combined annual max |
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| <b>VISION SERVICES</b><br>The carrier you choose for medical services will be your vision carrier as well. | <b>ODS PPO with HSA</b>   | <b>ODS Traditional PPO</b>  | <b>Kaiser HMO</b>   |
|  | You may visit any licensed ophthalmologist, optician, or optometrist. Not subject to deductible.  | You may visit any licensed ophthalmologist, optician, or optometrist. Not subject to deductible.  | <b>MUST USE KAISER FACILITIES ONLY</b>                              |
| <b>Routine Eye Exam</b>  | \$60 allowance every calendar year  | Routine Eye Exams: \$10 co-pay every 12 months  | \$15 co-pay   |
| <b>Lenses, Frames &amp; Contact Lens</b>   | Maximum plan allowance:<br>Single Lens \$78 (per pair)<br>Bifocal \$160 (per pair)<br>Trifocal/Progressive \$190 (per pair)<br>Contacts (elective) \$125<br>Contacts (medical necessary) \$131<br>Frames \$82<br><br>Benefit provided every calendar year for under age 18 and every 2 calendar years for 18+ | <u>Lenses &amp; Frames</u> : ODS pays 100% of the MPA up to \$200 every 12 mo. for age 18 & under and every 24 months for 18+<br><br><u>Contact Lens</u> : ODS pays 100% of the MPA up to \$200 every 12 mo. for age 18 & under and every 24 months for 18+ | \$150 allowance towards lenses, frames and contacts every 24 months |

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| <b>DENTAL SERVICES</b>   | <b>ODS Dental Plan</b>  | <b>Kaiser Dental Plan</b><br><b>MUST USE KAISER FACILITIES ONLY</b>   |
| <b>Deductible</b>  | \$50 per Member / \$150 per Family  | None  |
| <b>Annual Maximum</b>  | Up to \$1,000 per Member paid by ODS.   | None  |
| <b>Preventive</b>  | <b>Employee Pays</b>  | <b>Employee Pays</b>  |
| Routine Exam & X-rays<br>Prophylaxis (cleanings)<br>Sealants & Fluoride<br>Space Maintainers | 0% (deductible waived)<br><b>Benefits provided once every six months</b>                      | \$10 office visit co-pay<br><b>Exams: 2 in any 12 consecutive month period</b>  |
| <b>Basic</b>   | <b>After Deductible Employee Pays</b>   | <b>Employee Pays</b>  |
| Endodontics (pulpal therapy & root canal filling)<br>Restorative Fillings                    | 20% coinsurance   | \$10 office visit copay, then:<br>\$0 for Restorative Fillings<br><b>20% for Endodontics</b>                                  |
| <b>Major</b>   | <b>After Deductible Employee Pays</b>   | <b>Employee Pays</b>  |
| Crowns<br>Cast Restorations<br>Prosthetics (Dentures & Bridge Work)                          | 50% (Includes Oral Surgery & Periodontics)  | \$10 office visit co-pay, then:<br><b>50% coinsurance for all except</b><br><b>0% Oral Surgery</b><br><b>20% Periodontics</b> |
| <b>Orthodontia</b>   | 50% up to \$1000 lifetime maximum benefit per eligible member, then employee pays the balance | 50% up to \$1,000 lifetime maximum benefit per eligible member, then employee pays balance                                    |

**MONTHLY PREMIUM COSTS (2012 Monthly Premium Cap is \$1,346)**

| Choice of Medical & Dental Plan     | Combined Monthly Premium | Marion County's Monthly Cost | Employee's Monthly Cost | Employee's Twice-Monthly Deduction |
|-------------------------------------|--------------------------|------------------------------|-------------------------|------------------------------------|
| Kaiser HMO & Kaiser Dental          | \$1,384.30               | \$1,346.00                   | \$38.30                 | \$19.15                            |
| Kaiser HMO & ODS Dental             | \$1,377.67               | \$1,346.00                   | \$31.67                 | \$15.84                            |
| ODS Traditional PPO & Kaiser Dental | \$1,369.99               | \$1,346.00                   | \$23.99                 | \$12.00                            |
| ODS Traditional PPO & ODS Dental    | \$1,363.36               | \$1,346.00                   | \$17.36                 | \$8.68                             |
| ODS PPO/HSA & Kaiser Dental         | \$1,208.97               | \$1,208.97                   | \$0.00                  | \$0.00                             |
| ODS PPO/HSA & ODS Dental            | \$1,202.34               | \$1,202.34                   | \$0.00                  | \$0.00                             |

*Important Notice: The Women's Health & Cancer Rights Act of 1998 requires all plans to provide benefits for all mastectomy-related services including reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy (including lymphedemas). Call your carrier's customer service line for details.*