

Marion County Law Enforcement Association (MCLEA) 2012 MARION COUNTY HEALTH PLANS SUMMARY

Please Note: 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 your carrier: ODS at 1-888-217-2363, Kaiser Permanente at 503-361-5400. Claims will be paid per the carrier's information and contract.

MEDICAL SERVICES	ODS PPO Plan Preferred Provider Organization Plan Group # 10001745-1	Kaiser HMO Plan Health Management Organization Group #17372-AA-001
Annual Deductible	\$100 per person / \$300 family max	None
Annual Out-of-pocket Maximum	\$800 In-Network per person \$1,600 Out-of-Network per person	\$600 per member \$1200 family max
Annual Benefit Maximum	\$2,000,000	Unlimited
	After Deductible is met EMPLOYEE PAYS	EMPLOYEE PAYS
Office Visits	20% In-Network / 40% Out-of-Network	\$5 co-pay
Preventative Visits Routine Immunizations Men's Annual PRE/PSA Periodic Health Exams	No charge if In-Network* 40% Out-of-Network	No charge for routine health exams, newborn exams to age 2, or for immunizations
Women's Annual Preventive Exams	No charge if In-Network \$15 co-pay* Out-of-Network	No charge
Lab & X-Ray	20% In-Network / 40% Out-of-Network	No charge
Outpatient Surgery	20% In-Network / 40% Out-of-Network	\$5 co-pay
Hospital Semi-Private Room & Board and Inpatient Surgery	\$100 co-pay, plus: 20% In-Network / 40% Out-of-Network	\$0 co-pay
Maternity Care	<u>Dr. Visit:</u> 20% In-Network / 40% Out-of-Network <u>Hospital:</u> \$100 co-pay, plus: 20% In-Network / 40% Out-of-Network	<u>Office Visits:</u> \$0 co-pay <u>Hospital:</u> \$0 co-pay
Emergency Room & Urgent Care Visits	<u>ER:</u> \$100 co-pay*, plus: 20% In- Network* / 40% Out-of-Network <u>Urgent Care:</u> 20% In- Network* / 40% Out-of-Network	<u>ER:</u> \$5 co-pay <u>Urgent Care:</u> \$5 co-pay
Ambulance (Emergency Transport)	20% (\$5000 annual max for non-mental health & chemical dependency services)	\$0 co-pay
Prescriptions	25% plus difference between generic & brand name when a generic is avail.	\$10 generic/\$20 brand; only Kaiser formulary; 90-day mail order \$20/\$40
Naturopathic Care	20%* plus 25% for medically remedies	Not covered
Durable Medical Equipment	20% In-Network / 40% Out-of-Network	20% co-insurance
Mental Health/Chemical Dependency Note: Employees & covered family members may receive counseling through Cascade EAP at no cost for first 6 visits each year, and then Cascade will refer you to your health plan. Call Cascade for details 503-588-0777.	<u>Inpatient Treatment:</u> \$100 co-pay, plus: 20% In-Network / 40% Out-of-Network <u>Outpatient Treatment:</u> 20% In-Network / 40% Out-of-Network	Inpatient & Residential: \$0 Outpatient Treatment: \$5 per visit Day Treatment: \$5 per day

*Deductible is waived on these ODS services. On the ODS PPO Plan, pre-authorization is required for advanced diagnostic imaging. For all plans, deductibles do not apply to out-of-pocket maximums.

VISION SERVICES	ODS PPO Plan	Kaiser HMO Plan
	You may visit any licensed ophthalmologists, optician, or optometrist. No deductible.	MUST USE KAISER FACILITIES
Routine Eye Exam	\$10 co-pay, then \$0 up to MPA* every calendar year (Exam Includes refraction)	\$5 co-pay
Lenses, Frames & Contact Lenses *MPA = Maximum Plan Allowance	Lenses & Frames: \$10 co-pay, then \$0 up to MPA* every 2 calendar years for adults; every calendar year for children. Contacts: \$10 deductible, then \$0 of MPA* up to \$200 in lieu of lenses and frames every 2 calendar years.	Employee pays balance of the cost of lenses, frames or contacts after a \$150 allowance every 24 months.

DENTAL SERVICES	ODS DENTAL PLAN Group # 100001745- 17	KAISER DENTAL PLAN Group #17372-AA-004
Deductible	None	None
Annual Maximum Paid By Plan	\$1,500	None
Preventive (Class I)	EMPLOYEE PAYS	EMPLOYEE PAYS
Examination & X-rays; Sealants & Prophylaxis (cleanings)	No charge Once every six months for routine exams, bitewing x-rays, cleanings	No charge Cleanings: 2 visits in any 12 consecutive month period
Basic (Class II)	EMPLOYEE PAYS	EMPLOYEE PAYS
Limitations may apply, contact carrier Restorative Dentistry, Simple Extractions, Endodontics (pulpal therapy & root canal filling)	No charge (For posterior composite fillings, you pay cost difference of amalgam and composite.)	No charge
Major (Class III)	EMPLOYEE PAYS	EMPLOYEE PAYS
Limitations may apply, contact carrier Cast Restorations, Crowns Oral Surgery Periodontics (treatment of tissues supporting the teeth) Bridges, Dentures & Partials	50% coinsurance	Crown (Plastic/Acrylic/Steel) \$0 Crown (Gold/Porcelain) \$45 Oral Surgery & Periodontics \$0 Bridge Abutments \$45 Dentures \$95 each partial; \$65 full; \$25 reline
Orthodontia	EMPLOYEE PAYS	EMPLOYEE PAYS
	20% (up to \$700 lifetime maximum benefit per eligible member) then employee pays 100%	Not Covered

HEALTH PLAN PREMIUM COSTS (Effective January 1, 2012 through December 31, 2012)

Medical & Dental Plan Combinations	Combined Monthly Premium	Marion County's Monthly Cost	Employee's Monthly Cost	Twice-Monthly Deduction
Kaiser HMO & Kaiser Dental	1264.61	1201.38	63.23	31.62
Kaiser HMO & ODS Dental	1226.69	1165.36	61.33	30.67
ODS PPO Plan & Kaiser Dental	1499.06	1424.10	74.96	37.48
ODS PPO Plan & ODS Dental	1461.14	1388.08	73.06	36.53

Please Note: Marion County pays 95% and employees pays 5% of the combined monthly premiums.