Marion County
OREGON

2022 EMPLOYEE BENEFIT GUIDE

January 1, 2022 - December 31, 2022

MEDICAL | DENTAL | VISION | LIFE | DISABILITY & MORE

Non-MCLEA

Welcome to Marion County!

As part of the Marion County team, you play a vital role in serving the people of our community. The benefits in this guide are part of your overall compensation package. Included in this guide, you will find all the information you need to know about your benefits as a County employee. From health insurance to planning for retirement, Marion County makes sure you have the support you need through the different stages of your career and family life.

Our benefits team is here to support you. Let us know how we can help!

Overview

Table of Contents

LEVELS OF COVERAGE

Marion County employees can select from 4 levels of coverage for their health, dental, and vision coverage. We offer coverage for Employee Only; Employee and Spouse; Employee and Child(ren); or Employee and Family, which includes coverage for a Domestic Partner and their Children.

TAXATION OF BENEFITS

Medical, dental, and vision premium deductions, as well as FSA and HSA contributions, will come out of your paycheck before taxes (pre-tax). Voluntary Term Life insurance and Short Term Disability coverage deductions are after-tax deductions.

Who is Eligible?

WHO IS ELIGIBLE?

All active regular Marion County employees working a minimum of 20 hours per week. For new hires, employees become eligible for benefits beginning the first of the month following or coinciding with 30 days of employment.

Eligible dependents may also participate. These include:

- Your spouse
- Children under 26, including:
  - Natural child
  - Stepchild
  - Adopted child
  - Any other child for whom you are the legal guardian or are requited to provide support because of a qualified medical child support order
- A child over age 26 who is incapable of self support because of a physical or mental disability.

Marion County employees pay one rate for themselves and all enrolled family members.

MAKING CHOICES

The annual enrollment period is the one time of year you can change benefit plans or add/drop dependents outside of a qualified family status change as defined by the IRS. Such changes include:

- Marriage, divorce of legal separation
- Domestic Partnership status change
- Birth or adoption of a child
- Change in child's dependent status
- Death of a spouse, child or other qualified dependent
- Change in employment status or change in coverage under another employer-sponsored health plan

Please note: *If you experience a qualified family status change during the plan year, you must notify the Benefits team within 30 days of the event.*

Medical Insurance

For Non-MCLEA members, Marion County offers 3 medical plans – 2 plans are insured by PacificSource Health Plan and 1 plan is insured by Kaiser. Details about each plan are provided on the following pages but each plan provides comprehensive coverage and includes:

- Preventive care
- Pharmacy
- Telehealth
- Alternative care
- 24/7 care
- Online resources

PacificSource Plans

Both PacificSource Plans are PPO plans. This means you can see any licensed doctor. However, you will receive a richer level of benefits if you use a doctor or facility in their network. To see if your doctor is in the network, visit **www.pacificsource.com**. Search for doctors by name, clinic name, specialty, language, gender, hours of business and more.

With the **PPO Voyager 300** plan, you pay less in deductible and copays but you pay more each pay period. This plan may be a good choice if you want predictable costs. For example, a doctor's visit will cost $15, additional services may require a copay.

The **Voyager HSA 1400** plan is a qualified High Deductible Health Plan (HDHP) What does this mean? With the HDHP, you'll pay more out-of-pocket if you have medical expenses (until you've met the deductible), but you can use your Health Savings Account (HSA) to cover those costs. And you'll save each month by paying less for your premium. Preventive care is covered in full when received in-network whether or not you have met the deductible.

Learn more about HSAs on page 18.

Kaiser HMO Plan

If you choose the Kaiser HMO plan, all care must be received from a Kaiser physician in a Kaiser facility. Additionally, you must choose a Primary Care Physician (PCP) who will coordinate your care, meaning that you will need to start with your PCP before seeing a specialist, receiving prescriptions, having a surgery, etc. There are a few exceptions when you can self-refer, including alternative care benefits like chiropractic and acupuncture and OBGYNs. All members can go directly to the nearest emergency room, even if it's not a Kaiser facility, if experiencing a physical or mental emergency.

Visit **www.kp.org** to learn more.

Opt-Out

Do you have other health care coverage? You can choose to Opt-Out of Marion County's Health Plans and receive a monthly incentive. Proof of other coverage is required. Please contact Employee Benefits for more information.

NEED HELP?

PacificSource and Kaiser's Member Services team can help.

PacificSource: 877-977-9299

Kaiser: 800-813-2000

Be in the Know Before You Go

Insurance can be confusing. It has its own vocabulary. Understanding the terms below will help you make a better choice for yourself and your family.

Copay A set dollar amount that you pay when you receive services. For example, with the Kaiser HMO and PacificSource PPO plans, you pay $15 when you visit your doctor.

Deductible This is a set amount of amount of money that you must pay before the insurance company will pay a claim. Deductibles apply to more expensive services, like hospitalization.

Coinsurance After you have paid the deductible, you and the insurance company split the cost of care. For example, you pay 20% of the billed cost.

Out of Pocket Maximum (OOP)
This is the most you will pay for covered services in a calendar year. If you reach the OOP, the insurance company will pay 100% of eligible expenses for the rest of the calendar year.

Telemedicine – Medical Care at Your Fingertips

All Marion County health plans offer enhanced telemedicine experiences to employees who enroll in a medical plan. This gives you and your covered family members 24/7 access to high quality medical care. On the PacificSource PPO, the copay is $15 and on Kaiser HMO plans, telehealth visits are FREE. On the HSA plan, you pay a set fee for the visit until you have met the deductible.

PACIFICSOURCE - TELADOC

Teladoc is an affordable alternative included with most PacificSource plans. It gives you access to a doctor right where you are, using a mobile app on your phone or your computer. You can get a consult anytime, seven days a week.

For adults 18 and over, behavioral health therapists are also available to help with stress and anxiety, relationship and family problems, depression, work pressures, grieving, and trauma resolution.

HOW DOES IT WORK?

1. Set up an account
2. Fill out your medical history
3. Request a visit
4. Speak directly with a doctor

Teladoc physicians can write prescriptions and call them into your local pharmacy.

KAISER

You can receive access to care that fits your life. Talk to a health care professional from anywhere – by phone, email or video.

HOW DOES IT WORK?

Download the Kaiser mobile app or sign into www.kp.org to get started.

PacificSource – PPO Voyager 300

PacificSource HEALTH PLANS

Marion County Non-MCLEA

Medical Benefit Summary
Voyager 300+15_30 S3

Provider Network: **Voyager**

Deductible Per Calendar Year	In-network and Out-of-network	
Individual/Family	$300/$900	
Out-of-Pocket Limit Per Calendar Year	**In-network**	**Out-of-network**
Individual/Family	$5,000/$10,000	$10,000/$20,000

Note: Your actual costs for services provided by an out-of-network provider may exceed this plan's out-of-pocket limit for out-of-network services. In addition, out-of-network providers can bill you for the difference between the amount charged by the provider and the amount allowed by the insurance company, and this amount is not counted toward the out-of-network out-of-pocket limit. Please see allowable fee in the Definitions section of your member handbook.

The member is responsible for any amounts shown above, in addition to the following amounts:

Service/Supply	In-network Member Pays	Out-of-network Member Pays
Preventive Care		
Well baby/Well child care	No deductible, 0%	After deductible, 50%
Preventive physicals	No deductible, 0%	After deductible, 50%
Well woman visits	No deductible, 0%	After deductible, 50%
Preventive mammograms	No deductible, 0%	After deductible, 50%
Immunizations	No deductible, 0%	After deductible, 50%
Preventive colonoscopy	No deductible, 0%	After deductible, 50%
Prostate cancer screening	No deductible, 0%	After deductible, 50%
Professional Services		
Office and home visits	No deductible, $15	After deductible, 50%
Naturopath office visits	No deductible, $15	After deductible, 50%
Specialist office and home visits	No deductible, $15	After deductible, 50%
Telemedicine visits	No deductible, $15	After deductible, 50%
Office procedures and supplies	After deductible, 30%	After deductible, 50%
Surgery	After deductible, 30%	After deductible, 50%
Outpatient rehabilitation and habilitation services	After deductible, 30%	After deductible, 50%
Chiropractic manipulations and acupuncture ($1,000 per benefit year)	No deductible, 30%	No deductible, 30%

Refer to the carrier's plan summaries for limitations and exclusions

PacificSource – PPO Voyager 300, cont

Service/Supply	In-network Member Pays	Out-of-network Member Pays
Hospital Services		
Inpatient room and board	After deductible, $100/admit plus 30%	After deductible, $100/admit plus 50%
Inpatient rehabilitation and habilitation services	After deductible, $100/admit plus 30%	After deductible, $100/admit plus 50%
Skilled nursing facility care	After deductible, $100/admit plus 30%	After deductible, $100/admit plus 50%
Outpatient Services		
Outpatient medical surgery/services	After deductible, 30%	After deductible, 50%
Outpatient dental surgery/services	After deductible, $100 plus 30%	After deductible, $100 plus 50%
Outpatient at ambulatory surgery center	After deductible, 20%	After deductible, 50%
Advanced diagnostic imaging	After deductible, $100/test plus 30%	After deductible, $100/test plus 50%
Diagnostic and therapeutic radiology/lab and dialysis	No deductible, 30%	After deductible, 50%
Urgent and Emergency Services		
Urgent care center visits	No deductible, $15	After deductible, 50%
Emergency room visits – medical emergency	No deductible, $200 plus 30%^	No deductible, $200 plus 30%^
Emergency room visits – non-emergency	No deductible, $200 plus 30%^	No deductible, $200 plus 30%^
Ambulance, ground	After deductible, 30%	After deductible, 30%
Ambulance, air	After deductible, 30%	After deductible, 30%+
Maternity Services**		
Physician/Provider services (global charge)	After deductible, 30%	After deductible, 50%
Hospital/Facility services	After deductible, $100/admit plus 30%	After deductible, $100/admit plus 50%
Mental Health and Substance Use Disorder Services		
Office visits	No deductible, $15	No deductible, 50%
Inpatient care	After deductible, $100/admit plus 30%	After deductible, $100/admit plus 50%
Residential programs	After deductible, $100/admit plus 30%	After deductible, $100/admit plus 50%
Other Covered Services		
Allergy injections	After deductible, 30%	After deductible, 50%
Durable medical equipment	After deductible, 30%	After deductible, 50%
Home health services	After deductible, 30%	After deductible, 50%
Transplants	After deductible, $100/admit plus 30%	After deductible, $100/admit plus 50%

Refer to the carrier's plan summaries for limitations and exclusions

PacificSource – PPO Voyager 300, cont

PacificSource HEALTH PLANS

Prescription Drug Benefit Summary
OR 10-30-50P S4 PDL

Marion County Non-MCLEA

Formulary: Preferred Drug List (PDL)

This PacificSource health plan includes coverage for prescription drugs and certain other pharmaceuticals, subject to the information below. This plan complies with federal healthcare reform. To check which tier your prescription falls under, call our Customer Service team or visit PacificSource.com/drug-list.

The amount you pay for covered prescriptions at in-network and out-of-network pharmacies applies toward your plan's in-network medical out-of-pocket limit, which is shown on the Medical Benefit Summary. The co-payment and/or co-insurance for prescription drugs obtained from an in-network or out-of-network pharmacy are waived during the remainder of the calendar year in which you have satisfied the medical out-of-pocket limit.

PacificSource Expanded (Preventive) No-cost Drug List and Affordable Care Act Standard Preventive No-cost Drug List

Your prescription benefit includes certain outpatient drugs as a preventive benefit at no deductible, $0. This includes specific drugs that are taken regularly to prevent a disease or to keep a specific disease or condition from progressing. You can get a list of covered preventive drugs by contacting our Customer Service team or visit PacificSource.com/drug-list.

Each time a covered prescription is dispensed, you are responsible for any amounts shown above, in addition to the following amounts:

Service/ Supply	Incentive Drugs:	Tier 1 Member Pays	Tier 2 Member Pays	Tier 3 Member Pays
In-network Retail Pharmacy				
Up to a 30 day supply:	No deductible, 0%	No deductible, $10	No deductible, $30	No deductible, 50%
31 - 60 day supply:	No deductible, 0%	No deductible, $20	No deductible, $60	No deductible, 50%
61 - 90 day supply:	No deductible, 0%	No deductible, $30	No deductible, $90	No deductible, 50%
In-network Mail Order Pharmacy				
Up to a 30 day supply:	No deductible, 0%	No deductible, $10	No deductible, $30	No deductible, 50%
31 - 60 day supply:	No deductible, 0%	No deductible, $20	No deductible, $60	No deductible, 50%
61 - 90 day supply:	No deductible, 0%	No deductible, $30	No deductible, $90	No deductible, 50%
Compound Drugs**				
Up to a 90 day supply:	No deductible, 50%			

PacificSource – PPO Voyager 300, cont

Service/ Supply	Incentive Drugs:	Tier 1 Member Pays	Tier 2 Member Pays	Tier 3 Member Pays
Out-of-network Pharmacy				
30 day max fill, no more than three fills allowed per year:		No deductible, 50%		

	Tier 1, Tier 2, and Tier 3 Member Pays
Specialty Drugs – In-network Specialty Pharmacy	
Up to a 30 day supply:	No deductible, $50
Specialty Drugs – Out-of-network Specialty Pharmacy	
30 day max fill, no more than three fills allowed per year:	No deductible, $50

**Compounded medications are subject to a preauthorization process. Compounds are generally covered only when all commercially available formulary products have been exhausted and all the ingredients in the compounded medications are on the applicable formulary.

MAC A - Regardless of the reason or medical necessity, if you receive a brand name drug or if your provider prescribes a brand name drug when a generic is available, you will be responsible for the brand name drug's co-payment and/or co-insurance plus the difference in cost between the brand name and generic drug. The cost difference between the brand name and generic drug does not apply toward the medical plan's out-of-pocket limit. Does not apply to preventive bowel prep kit medications covered under USPSTF guidelines.

If your provider prescribes a brand name contraceptive due to medical necessity it may be subject to preauthorization for coverage at no charge.

See your member handbook for important information about your prescription drug benefit, including which drugs are covered, limitations, and more.

PacificSource – Voyager HDHP 1400

PacificSource HEALTH PLANS

Marion County Non-MCLEA

Medical Benefit Summary
Voyager HSA 1400_20+Rx
Non-embedded S3

Provider Network: Voyager

Deductible Per Calendar Year	In-network and Out-of-network	
Individual/Family	$1,400/$2,800	
Out-of-Pocket Limit Per Calendar Year	**In-network**	**Out-of-network**
Individual/Family	$3,000/$6,000	$7,600/$15,200

Note: Your actual costs for services provided by an out-of-network provider may exceed this plan's out-of-pocket limit for out-of-network services. In addition, out-of-network providers can bill you for the difference between the amount charged by the provider and the amount allowed by the insurance company, and this amount is not counted toward the out-of-network out-of-pocket limit. Please see allowable fee in the Definitions section of your member handbook.

The member is responsible for any amounts shown above, in addition to the following amounts:

Service/Supply	In-network Member Pays	Out-of-network Member Pays
Preventive Care		
Well baby/Well child care	No deductible, 0%	After deductible, 40%
Preventive physicals	No deductible, 0%	After deductible, 40%
Well woman visits	No deductible, 0%	After deductible, 40%
Preventive mammograms	No deductible, 0%	After deductible, 40%
Immunizations	No deductible, 0%	After deductible, 40%
Preventive colonoscopy	No deductible, 0%	After deductible, 40%
Prostate cancer screening	No deductible, 0%	After deductible, 40%
Professional Services		
Office and home visits	After deductible, 20%	After deductible, 40%
Naturopath office visits	After deductible, 20%	After deductible, 40%
Specialist office and home visits	After deductible, 20%	After deductible, 40%
Telemedicine visits	After deductible, 20%	After deductible, 40%
Office procedures and supplies	After deductible, 20%	After deductible, 40%
Surgery	After deductible, 20%	After deductible, 40%
Outpatient rehabilitation and habilitation services	After deductible, 20%	After deductible, 40%
Chiropractic manipulations and acupuncture ($1,500 per benefit year)	After deductible, 20%	After deductible, 40%

Refer to the carrier's plan summaries for limitations and exclusions

PacificSource – Voyager HDHP 1400, cont

Service/Supply	In-network Member Pays	Out-of-network Member Pays
Hospital Services		
Inpatient room and board	After deductible, 20%	After deductible, 40%
Inpatient rehabilitation and habilitation services	After deductible, 20%	After deductible, 40%
Skilled nursing facility care	After deductible, 20%	After deductible, 40%
Outpatient Services		
Outpatient surgery/services	After deductible, 20%	After deductible, 40%
Outpatient at ambulatory surgery center	After deductible, 10%	After deductible, 40%
Advanced diagnostic imaging	After deductible, 20%	After deductible, 40%
Diagnostic and therapeutic radiology/lab and dialysis	After deductible, 20%	After deductible, 40%
Urgent and Emergency Services		
Urgent care center visits	After deductible, 20%	After deductible, 40%
Emergency room visits – medical emergency	After deductible, 20%	After deductible, 20%
Emergency room visits – non-emergency	After deductible, 20%	After deductible, 20%
Ambulance, ground	After deductible, 20%	After deductible, 20%
Ambulance, air	After deductible, 20%	After deductible, 20%+
Maternity Services**		
Physician/Provider services (global charge)	After deductible, 20%	After deductible, 40%
Hospital/Facility services	After deductible, 20%	After deductible, 40%
Mental Health and Substance Use Disorder Services		
Office visits	After deductible, 20%	After deductible, 40%
Inpatient care	After deductible, 20%	After deductible, 40%
Residential programs	After deductible, 20%	After deductible, 40%
Other Covered Services		
Allergy injections	After deductible, 20%	After deductible, 40%
Durable medical equipment	After deductible, 20%	After deductible, 40%
Home health services	After deductible, 20%	After deductible, 40%
Transplants	After deductible, 20%	After deductible, 40%

This is a brief summary of benefits. Refer to your member handbook for additional information or a further explanation of benefits, limitations, and exclusions.

** Medically necessary services, medication, and supplies to manage diabetes during pregnancy from conception through six weeks postpartum will not be subject to a deductible, co-payment, or co-insurance.

Refer to the carrier's plan summaries for limitations and exclusions

PacificSource – Voyager HDHP 1400, cont

Service/Supply	In-network Member Pays	Out-of-network Member Pays
Hospital Services		
Inpatient room and board	After deductible, 20%	After deductible, 40%
Inpatient rehabilitation and habilitation services	After deductible, 20%	After deductible, 40%
Skilled nursing facility care	After deductible, 20%	After deductible, 40%
Outpatient Services		
Outpatient surgery/services	After deductible, 20%	After deductible, 40%
Outpatient at ambulatory surgery center	After deductible, 10%	After deductible, 40%
Advanced diagnostic imaging	After deductible, 20%	After deductible, 40%
Diagnostic and therapeutic radiology/lab and dialysis	After deductible, 20%	After deductible, 40%
Urgent and Emergency Services		
Urgent care center visits	After deductible, 20%	After deductible, 40%
Emergency room visits – medical emergency	After deductible, 20%	After deductible, 20%
Emergency room visits – non-emergency	After deductible, 20%	After deductible, 20%
Ambulance, ground	After deductible, 20%	After deductible, 20%
Ambulance, air	After deductible, 20%	After deductible, 20%+
Maternity Services**		
Physician/Provider services (global charge)	After deductible, 20%	After deductible, 40%
Hospital/Facility services	After deductible, 20%	After deductible, 40%
Mental Health and Substance Use Disorder Services		
Office visits	After deductible, 20%	After deductible, 40%
Inpatient care	After deductible, 20%	After deductible, 40%
Residential programs	After deductible, 20%	After deductible, 40%
Other Covered Services		
Allergy injections	After deductible, 20%	After deductible, 40%
Durable medical equipment	After deductible, 20%	After deductible, 40%
Home health services	After deductible, 20%	After deductible, 40%
Transplants	After deductible, 20%	After deductible, 40%

This is a brief summary of benefits. Refer to your member handbook for additional information or a further explanation of benefits, limitations, and exclusions.

** Medically necessary services, medication, and supplies to manage diabetes during pregnancy from conception through six weeks postpartum will not be subject to a deductible, co-payment, or co-insurance.

+ Out-of-network air ambulance coverage is covered at 200 percent of the Medicare allowance. You may be held responsible for the amount billed in excess. Please see your member handbook for additional information or contact our Customer Service team with questions.

Refer to the carrier's plan summaries for limitations and exclusions

PacificSource – Voyager HDHP 1400, cont

PacificSource HEALTH PLANS

Prescription Drug Benefit Summary
OR 20P 1400D S4 PDL

Marion County Non-MCLEA

Formulary: Preferred Drug List (PDL)

This PacificSource health plan includes coverage for prescription drugs and certain other pharmaceuticals, subject to the information below. This plan complies with federal healthcare reform. To check which tier your prescription falls under, call our Customer Service team or visit PacificSource.com/drug-list.

The amount you pay for covered prescriptions at in-network and out-of-network pharmacies applies toward your plan's in-network medical out-of-pocket limit, which is shown on the Medical Benefit Summary. The co-payment and/or co-insurance for prescription drugs obtained from an in-network or out-of-network pharmacy are waived during the remainder of the calendar year in which you have satisfied the medical out-of-pocket limit.

Medical Deductible
You must meet the medical deductible, which is shown on the Medical Benefit Summary, before your prescription drug benefits begin.

PacificSource Expanded (Preventive) No-cost Drug List and Affordable Care Act Standard Preventive No-cost Drug List
Your prescription benefit includes certain outpatient drugs as a preventive benefit at no deductible, $0. This includes specific drugs that are taken regularly to prevent a disease or to keep a specific disease or condition from progressing. You can get a list of covered preventive drugs by contacting our Customer Service team or visit PacificSource.com/drug-list.

Each time a covered prescription is dispensed, you are responsible for any amounts shown above, in addition to the following amounts:

Service/ Supply	Incentive Drugs:	Tier 1 Member Pays	Tier 2 Member Pays	Tier 3 Member Pays
In-network Retail Pharmacy				
Up to a 90 day supply:	No deductible, 0%	After deductible, 20%	After deductible, 20%	After deductible, 20%
In-network Mail Order Pharmacy				
Up to a 90 day supply:	No deductible, 0%	After deductible, 20%	After deductible, 20%	After deductible, 20%
Compound Drugs**				
Up to a 90 day supply:	After deductible, 20%			
Out-of-network Pharmacy				
30 day max fill, no more than three fills allowed per year:	After deductible, 50%			

Refer to the carrier's plan summaries for limitations and exclusions

PacificSource – Voyager HDHP 1400, cont

	Tier 1, Tier 2, and Tier 3 Member Pays
Specialty Drugs – In-network Specialty Pharmacy	
Up to a 30 day supply:	After deductible, 20%
Specialty Drugs – Out-of-network Specialty Pharmacy	
30 day max fill, no more than three fills allowed per year:	After deductible, 20%

**Compounded medications are subject to a preauthorization process. Compounds are generally covered only when all commercially available formulary products have been exhausted and all the ingredients in the compounded medications are on the applicable formulary.

MAC A - Regardless of the reason or medical necessity, if you receive a brand name drug or if your provider prescribes a brand name drug when a generic is available, you will be responsible for the brand name drug's co-payment and/or co-insurance plus the difference in cost between the brand name and generic drug after the medical deductible is met. The cost difference between the brand name and generic drug does not apply toward the medical plan's deductible or out-of-pocket limit. Does not apply to preventive bowel prep kit medications covered under USPSTF guidelines.

If your provider prescribes a brand name contraceptive due to medical necessity it may be subject to preauthorization for coverage at no charge.

See your member handbook for important information about your prescription drug benefit, including which drugs are covered, limitations, and more.

Kaiser HMO

Summary of Medical Benefits

All plans offered and underwritten by Kaiser Foundation Health Plan of the Northwest. 500 NE Multnomah St., Suite 100, Portland, OR 97232

Member Services: 1-800-813-2000

Oregon DED PLAN B 500/20/20%/3000 **1/1/2022 - 12/31/2022**

Marion County **Group Number: 1522-042**

Calendar year is the time period (Year) in which dollar, day, and visit limits, Deductibles and Out-of-Pocket Maximums accumulate.	
Deductible	
Self-only Deductible per Year (for a Family of one Member)	$500
Individual Family Member Deductible per Year (for each Member in a Family of two or more Members)	$500
Family Deductible per Year (for an entire Family)	$1,500
Out-of-Pocket Maximum [1]	
Self-only Out-of-Pocket Maximum per Year (for a Family of one Member)	$3,000
Individual Family Member Out-of-Pocket Maximum per Year (for each Member in a Family of two or more Members)	$3,000
Family Out-of-Pocket Maximum per Year (for an entire Family)	$9,000
Office Visits	**You pay**
Routine preventive physical exam	$0
Telehealth (phone/video)	$0
Primary Care	$15
Specialty Care	$30
Urgent Care	$40
Tests (outpatient)	**You pay**
Preventive Tests	$0
Laboratory	$15 per department visit
X-ray, imaging, and special diagnostic procedures	$15 per department visit
CT, MRI, PET scans	$100 per department visit
Medications (outpatient)	**You pay**
Prescription drugs (up to a 30 day supply)	$10 generic / $30 preferred brand / 50% Coinsurance (up to $100 max) non-preferred brand
Mail Order Prescription drugs (up to a 90 day supply)	$20 generic / $60 preferred brand / 50% Coinsurance (up to $200 max) non-preferred brand
Administered medications, including injections (all outpatient settings)	$0
Nurse treatment room visits to receive injections	$10
Maternity Care	**You pay**
Scheduled prenatal care visits and postpartum visits	$0
Laboratory	$15 per department visit
X-ray, imaging, and special diagnostic procedures	$15 per department visit

LGnooPO50122 2C22

KAISER PERMANENTE®

Refer to the carrier's plan summaries for limitations and exclusions

Kaiser HMO, cont

Inpatient Hospital Services	$100 per day up to $500 per admission
Hospital Services	**You pay**
Ambulance Services (per transport)	20% Coinsurance after Deductible
Emergency services	$200 after Deductible (Waived if admitted)
Inpatient Hospital Services	$100 per day up to $500 per admission
Outpatient Services (other)	**You pay**
Outpatient surgery visit	$20
Chemotherapy/radiation therapy visit	$30
Durable medical equipment	20% Coinsurance after Deductible
Physical, speech, and occupational therapies (20 visits per therapy per Year)	$30
Skilled Nursing Facility Services	**You pay**
Inpatient skilled nursing Services (up to 100 days per Year)	$0
Mental Health and Chemical Dependency Services	**You pay**
Outpatient Services	$15 per visit
Inpatient hospital & residential Services	$100 per day up to $500 per admission
Alternative Care (self-referred)	**You pay**
Acupuncture Services (up to 12 visits per Year)	$40 per visit
Chiropractic Services (up to 20 visits per Year)	$40 per visit
Massage Therapy (up to 12 visits per Year)	$25 per visit
Naturopathic Medicine	$15 per visit
Vision Services	**You pay**
Routine eye exam (Covered until the end of the month in which Member turns 19 years of age.)	$0
Vision hardware and optical Services (Covered until the end of the month in which Member turns 19 years of age.)	No charge for eyeglass lenses, frames or contact lenses every 12 months.
Routine eye exam (For members 19 years and older.)	$20
Vision hardware and optical Services (For members 19 years and older.)	Initial allowance of up to $200 for prescription eyeglasses or conventional or disposable prescription contact lenses, including Medically Necessary contact lenses, not more than once every Year.

[1] Refer to your Evidence of Coverage (EOC) for benefits that may not apply to Out-of-Pocket Maximum.

Plan is subject to exclusions and limitations. A complete list of the exclusions and limitations is included in the Evidence of Coverage (EOC). Sample EOCs are available upon request or you may go to **http://www.kp.org/plandocuments**

Questions? Call Member Services (M-F, 8 am-6 pm) or visit **kp.org** Portland area: 503-813-2000
All other areas: 1-800-813-2000 TTY.711. Language Interpretation Services, all areas 1-800-324-8010

This is not a contract. This condensed summary of benefits does not fully describe your benefit coverage with Kaiser Foundation Health Plan of the Northwest. For more details on benefit coverage, claims review, and adjudication procedures, please see your EOC or call Member Services. In the case of a conflict between this summary and the EOC, the EOC will prevail.

LGnonPO50122 2C22

KAISER PERMANENTE®

Health Savings Account (HSA)

WHAT IS A HEALTH SAVINGS ACCOUNT?

A Health Savings Account (HSA) is an account that is funded with pre-tax dollars by you and Marion County on a prorated basis. These funds can be used to help pay for eligible health care expenses not covered by your insurance plan including deductible and coinsurance. **You must enroll in the PacificSource Voyager HDHP 1400 plan to participate.**

	2022 IRS Annual HSA Limits
Employee	$3,650
Employee+ Spouse	$7,300
Employee+ Child(ren)	$7,300
Family	$7,300

If you are age 55 or older you can make an additional annual contribution of $1,000.

WHO IS ELIGIBLE FOR AN HSA?

Anyone who is:

- Covered by a High Deductible Health Plan
- Employees whose spouse is not currently participating in a medical flexible spending account
- Not covered under another medical health plan that is not a High Deductible Health Plan (including a spouse's Health Care Flexible Spending Account)
- Not enrolled in Medicare or Medicaid benefits
- Not eligible to be claimed on another person's tax return
- Not eligible for Tricare or have received benefits from the Veterans Administration in the past three months

WHEN TO USE AN HSA ACCOUNT?

Dental Insurance

At Marion County, we're proud to offer both Delta Dental PPO and Kaiser HMO dental plans so you can pick the plan that works best for you.

Each plan has different advantages.

- With the Delta plan, you may see any licensed provider. Delta Dental has the largest dental network in the country. When you use an in-network provider, you will pay less and your $2,000 annual maximum benefit will go further.

  Additionally, Preventive Services, like annual cleanings, do not count against the annual maximum benefit that Delta will pay.

- With the Kaiser plan, you must use a Kaiser dentist at a Kaiser facility. This can offer convenience by having all care, medical, dental and vision, in the same location. The most that Kaiser will pay toward dental services in a calendar year is $2,000. Preventive services do count toward the annual maximum.

Both plans cover preventive services in full and offer orthodontia benefits for children under age 19.

NEED HELP?

Delta Dental and Kaiser's Member Services team can help.

Delta Dental: 888-217-2363
Kaiser: 800-813-2000

Delta Dental PPO

Delta Dental Premier Plan Benefit Summary

DELTA DENTAL
Delta Dental of Oregon & Alaska

Marion County - Non-MCLEA

Group ID: 10001745

Calendar year costs	
Calendar year maximum, per member	$2,000
Calendar year deductible, per member	$50
Calendar year maximum deductible, per family	$150
Class 1* (Services do not apply to the calendar year max)	
Periodic Examinations / X-rays	100%
Prophylaxis (cleanings) / Periodontal Maintenance	100%
Sealants	100%
Space Maintainers	100%
Topical Application of Fluoride	100%
Class 2	
Simple Extractions (non -surgical)	80%
Endodontics (pulp therapy & root canal filling)	80%
Restorative Fillings	80%
Class 3	
Oral Surgery (extrations & certain minor surgical procedures)	
Periodontics (treatment of tissues supporting teeth)	50%
Crowns and other cast restorations	50%
Dentures and bridges (construction or repair of fixed bridges, partial, and complete dentures)	50%
Implants	50%

* Deductible waived for preventive services.

This is a benefit summary only. For a more detailed description of benefits, refer to your member handbook.

Adult & Child Ortho 1000	
Lifetime maximum	$1,000
	What members pay
Members age 19+	50%
Members under age 19	50%

Refer to the carrier's plan summaries for limitations and exclusions

Kaiser Dental Plan

Summary of Dental Benefits

All plans offered and underwritten by Kaiser Foundation Health Plan of the Northwest. 500 NE Multnomah St., Suite 100, Portland, OR 97232

Membership Services: 1-800-813-2000

Oregon R265 **1/1/2022 - 12/31/2022**

Marion County **Group Number: 1522-048**

Benefit Maximum per Calendar Year	$2,000
	You pay
Dental Office Visit Charge – Per visit	$0
Deductible (Per Calendar Year; applies to all services unless otherwise indicated)	
For one Member	$25
For an entire Family	$75
Preventive and Diagnostic Services (Not subject to or counted toward the Deductible)	
Oral exam	$0
X-rays	$0
Teeth cleaning	$0
Fluoride	$0
Minor Restoration Services	
Routine fillings	$0 after Deductible
Plastic and steel crowns	$0 after Deductible
Simple extractions	$0 after Deductible
Oral Surgery Services	
Surgical tooth extractions	$0 after Deductible
Periodontics	
Treatment of gum disease	20% Coinsurance after Deductible
Scaling and root planing	20% Coinsurance after Deductible
Endodontics	
Root canal therapy	20% Coinsurance after Deductible
Major Restoration Services	
Gold or porcelain crowns	50% Coinsurance after Deductible
Bridges	50% Coinsurance after Deductible
Removable Prosthetic Services	
Full upper and lower dentures	50% Coinsurance after Deductible
Partial dentures	50% Coinsurance after Deductible
Relines	50% Coinsurance after Deductible
Rebases	50% Coinsurance after Deductible
Nitrous oxide (Not subject to or counted toward the Deductible or Benefit Maximum)	
Adults and children age 13 years and older	$25
Children age 12 years and younger	$0
Orthodontics	All Members: 50% of Charges up to the $1,000 Lifetime Benefit Maximum, and 100% of Charges thereafter.

ORLGDental0122

KAISER PERMANENTE®

Refer to the carrier's plan summaries for limitations and exclusions

Vision Insurance

If you enroll in a medical plan, you will receive a vision benefit. The vision benefits are the same for PacificSource and Kaiser but the network providers are different. Visit www.pacificsource.com and www.kaiserpermanente.org to find in-network providers. You can use out-of-network providers but the insurance company will reimburse you up to a pre-defined limit. You will have to pay at time of service and submit a claim for reimbursement.

Note: if you enroll in PacificSource and use Costco, the eye exam will be covered at the in-network level if the optometrist is in PacificSource's network. Materials, like frames and lenses, are covered at the out-of-network level.

PACIFICSOURCE

Service/Supply	In-network Member Pays	Out-of-network Member Pays
Members Age 18 and Younger		
Eye exam	No deductible, $10	No deductible, $10 then 0% up to $45 then 100%
Vision hardware	No deductible, 0% for one pair per year for frames and/or lenses	No deductible, 0% for one pair per year up to $75 then 100% for frames and/or lenses
Members Age 19 and Older		
Eye exam	No deductible, $10	No deductible, $10 then 0% up to $45 then 100%
Single vision lenses	No deductible, 0%	No deductible, 0% up to $30 then 100%
Bifocal lenses	No deductible, 0%	No deductible, 0% up to $50 then 100%
Trifocal lenses	No deductible, 0%	No deductible, 0% up to $65 then 100%
Lenticular lenses	No deductible, 0%	No deductible, 0% up to $100 then 100%
Progressive lenses	No deductible, 0%	No deductible, 0% up to $50 then 100%
Frames	No deductible, 0% up to $200 then 100%	No deductible, 0% up to $70 then 100%
Contact Lenses (in lieu of glasses)		
Contact lenses	No deductible, 0% up to $200 then 100%	No deductible, 0% up to $105 then 100%

Benefit Limitations: One vision exam is covered every benefit year. One pair of lenses and frames are covered every year. Contact lenses are covered every year. Elective contact lenses are in lieu of frames and lenses. Anti-reflective coatings and scratch resistant coatings are covered.

KAISER

Vision Services	You pay
Routine eye exam (Covered until the end of the month in which Member turns 19 years of age.)	$0
Vision hardware and optical Services (Covered until the end of the month in which Member turns 19 years of age.)	No charge for eyeglass lenses, frames or contact lenses every 12 months.
Routine eye exam (For members 19 years and older.)	$20
Vision hardware and optical Services (For members 19 years and older.)	Initial allowance of up to $200 for prescription eyeglasses or conventional or disposable prescription contact lenses, including Medically Necessary contact lenses, not more than once every Year.

Refer to the carrier's plan summaries for limitations and exclusions

Flexible Spending Account (FSA)

WHAT IS A FLEXIBLE SPENDING ACCOUNT?

A Flexible Spending Account (FSA), also known as a reimbursement account, allows you to pay for a variety of out-of-pocket health care and dependent care expenses with pre-tax dollars. The accounts are administered by Navia Benefit Solutions. You will be able to charge all your qualified expenses on one debit card in addition to submitting claims for reimbursement. Marion County's Health Care and Dependent Care Reimbursement Accounts allow you to use tax-free dollars to reimburse yourself for a wide variety of health and dependent care expenses that aren't covered through your other benefit plans.

HEALTH CARE FSA

Health care expenses for yourself and your dependents—such as deductibles, coinsurance, and copays—are eligible for reimbursement from your Health Care account. The annual election maximum amount is currently $2,550 for the plan year.

If you enroll in the PacificSource HSA medical plan, you cannot enroll in a Health Care FSA.

DEPENDENT CARE FSA

Expenses for dependent care services for children under age 13, a disabled spouse, or incapacitated parent are eligible for reimbursement from your Dependent Care account if you incur them while you and your spouse work or attend school full-time. The annual election maximum amount is $5,000 per household ($2,500 if married but filing separately) per year.

Visit www.naviabenefits.com to learn more about these benefits.

RULES AND REGULATIONS – PLAN CAREFULLY

Plan your annual Flexible Spending Account (FSA) contribution amounts carefully; the election you make when you enroll is binding for the entire plan year (January 1 to December 31) unless you have a qualifying status change. Additionally, the IRS imposes some rules and restrictions on the way you can use FSAs:

- If you incur fewer expenses than you expected to your Health FSA, you will be able to roll-over a maximum of $500 into the next plan year. Any remaining money will be forfeited if not used by the end of the plan year.
- If you incur fewer expenses than you expected in your Dependent Care FSA, you forfeit any money remaining in your Dependent Care FSA at the end of the year.

Commuter & Transit Benefits

REGISTERING YOUR ACCOUNT

If you are new to Navia Benefit Solutions visit **www.naviabenefits.com**, click "Register" in the upper-right corner of the screen and select "I'm a participant."

You will need your 3-character employer code. This code can be found in your original "GoNavia Commuter Now Available" email notification or by simply calling Customer Service.

Shortly after completing the online form, you will receive an email confirmation to complete your registration.

SELECTING YOUR MONTHLY BENEFIT AMOUNT

Step 1: Login as a participant to **www.naviabenefits.com**. If you have not registered yet, you will need to complete the registration process.
Step 2: Once logged in, select the "GoNavia Commuter Orders" link under the "My Tools" section after scrolling down the screen.
Step 3: Select your benefit.
Step 4: Enter the dollar amount for your order.
Step 5: Select the months you would like to have your order recur.
Step 6: Once you've confirmed your order and agreed to the terms and conditions select "place my order".

You're finished! You will receive a confirmation email once your order has been submitted.

NEED HELP?

Go to:
www.naviabenefits.com

Call:
800-669-3539
(M-F, 5 a.m. – 5 p.m., PST)

Email:
customerservice@
naviabenefits.com

The deadline to place your monthly order is the 20th of each month.

Life and AD&D Insurance

BASIC LIFE AND AD&D INSURANCE

Marion County provides both Basic Life Insurance, and Accidental Death and Dismemberment (AD&D) insurance at no cost to you. These coverages are provided through New York Life and are for all active employees working a minimum of .5 full-time equivalent per week. **The benefit is 1 times your annual salary, rounded up to the next $1,000 (e.g., $47,500 would be rounded up to $48,000).**

Life insurance provides financial security for the people who depend on you. Your beneficiaries will receive a lump sum payment if you pass away. Accidental Death & Dismemberment (AD&D) insurance provides your beneficiaries a lump sum payment if you pass away as a direct result of an injury/accident while employed by Marion County.

BENEFICIARY DESIGNATION

A beneficiary is the person you designate to receive a benefit payment. You can change who is designated as your beneficiary by contacting Human Resources.

Monthly Employee & Spouse Rates per $10,000 of Voluntary Life Benefit		
Age	**Non-smoker Rates**	**Smoker Rates**
Under 30	$1.46	$1.92
30-34	$1.51	$2.01
35-39	$1.79	$2.46
40-44	$2.54	$3.60
45-49	$4.00	$5.70
50-54	$5.84	$8.46
55-59	$9.57	$13.60
60-64	$11.30	$16.10
65-69	$21.16	$29.38
70-74	$37.61	$50.65
75-79	$56.05	$72.68
80-89	$103.06	$128.67
90+	$259.39	$324.09
Monthly Child Rates - $2,000 / $5,000 / $10,000 of Benefit		
To age 23; to 26 for students	$0.40 / $1.00 / $2.00	

VOLUNTARY LIFE INSURANCE

As an additional benefit to employees, Marion County offers employees the opportunity to elect voluntary life insurance for themselves and dependents at discounted group pricing with convenient payroll deductions.

Note: *Dependents are eligible for voluntary life only when the employee elects coverage for self. Spouse voluntary life premiums are based upon the spouse's age.*

VOLUNTARY LIFE BENEFIT AMOUNT

Employees: Employees can elect $10,000 increments up to the lesser of 6x their basic annual earnings or $300,000.

Spouses: Spouse coverage is available in $10,000 increments up to the lesser of 100% of the employee's amount or $300,000.

Child(ren): Employees can elect $2,000, $5,000 or $10,000 worth of coverage for unmarried children to age 23 or under age 26 for full-time students. You pay one monthly rate for all children.

GUARANTEE ISSUE AMOUNTS

If you are newly benefit eligible, be sure to take advantage of the one-time opportunity to purchase guarantee issue amounts up to $50,000 for employees and $10,000 for spouses, no underwriting required!

Outside of your new hire eligibility period, all requests for voluntary life insurance must provide proof of good health.

CALCULATING YOUR MONTHLY COST

1. Decide the total amount of coverage you want to purchase.
2. Divide the amount by $10,000.
3. Multiply the result by the rate listed for your age and your smoker status.

For example, if a non-smoking 40-year-old wanted to purchase $50,000 of coverage, the cost would be 5 x $2.54 or $12.70 each month.

Short and Long Term Disability

Marion County's Short and Long Term Disability coverage protects your income and helps you pay your household expenses if you become disabled and cannot work for an extended period of time.

These benefits are insured by New York Life.

LONG TERM DISABILITY (EMPLOYER PAID)

Elimination Period: 90 days

Benefit: 66.67% of monthly base pay to a monthly maximum amount of $5,000

Benefit Duration: As long as you remain disabled until Social Security Normal Retirement Age

SHORT TERM DISABILITY (VOLUNTARY – EMPLOYEE PAID)

Elimination Period: 14 days for accident or illness

Benefit: 60% of weekly pay up to $1,500 per week

Benefit Duration: Up to 11 weeks

New Hires can enroll in the voluntary Short Term Disability plan without providing evidence of insurability. If you enroll in voluntary program outside of your new hire window, you will need to provide evidence of insurability.

Monthly Employee Short Term Disability Rates	
Age	**Rate per $10 of weekly benefit**
Under 55	$0.379
55-59	$0.464
60-64	$0.547
65-99	$0.601

KrowdFit

KrowdFit provides an all-inclusive wellness engagement platform focused on rewarding the effort members make to consistently engage in living a healthy, active lifestyle with weekly cash rewards up to $5,000 per person. It is available to all benefits-eligible employees and begins the first of the month following or coinciding with your date of hire. Visit **www.krowdfit.com** to sign up.

KrowdFit is the only cash-back wellness incentive program to pay out weekly cash rewards, from KrowdFit's unlimited cash rewards pool. The rewards pool increases as new members join allowing KrowdFit to pay out to more and more people every week! In addition to KrowdFit's challenges, Marion County sponsors our own challenges giving you more chances to win. Members have the opportunity to win unlimited cash rewards but may not win the same drawing two times in a row.

Employee Assistance Program (EAP)

As part of Marion County's comprehensive benefit offerings, employees have access to additional benefits offered through Canopy. These benefits are confidential and provided at no charge to you and your family members. ***This benefit is available to all employees whether or not you choose to enroll in other benefits***.

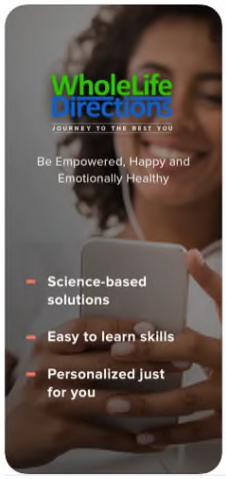
Go online or call for more information on all of the additional benefits listed below:

- In-person counseling
- Telehealth and video counseling
- Home ownership program
- Childcare Services
- Eldercare Services
- Fertility Health and Family Building
- Financial Coaching
- Identity Theft
- Legal Services and Tools
- Life Coaching
- Discounts to wellness tools

Visit **my.canopywell.com** to get started.

WholeLife Directions App

Included in the Employee Assistance Program from Canopy is WholeLife Directions. This tool can help bring awareness to your current health status and provide self-use programs to help you feel better. It starts with the WholeLife Scale, an emotional wellness survey to learn more about yourself, including areas where you might be able to make some positive changes. Download the WholeLife Directions app from Apple Store or Google Play.



Get started by completing the WholeLife Scale. This will take approximately 5-8 minutes to complete. Based on the results, you will receive customized recommendations that can support your wellness goal.

Visit **www.wholelifedirections.com** to get started.

Family & Medical Leave

The Family and Medical Leave Act (FMLA) and the Oregon Family Leave Act (OFLA) entitle eligible employees of covered employers to take unpaid, job-protected leave for specified family and medical reasons and allows for continuation of health benefits during the leave. Federal and state laws determine eligibility, if your absence qualifies as FMLA or OFLA, and how much leave time you may take.

FMLA and OFLA are protected leave programs, they are not paid leave programs. Any absences under these programs are covered via an employee's leave accruals (sick, vacation, etc.) to the extent available; unless otherwise outlined in Marion County Personnel Rules or a Collective Bargaining Agreement.

FMLA ELIGIBILITY

- You must have been employed by Marion County for a total of at least 12 months (if months are not consecutive, there can be no more than a seven-year break in service), and
- You must have worked for at least 1,250 hours in the 12-month period immediately preceding the leave.

OFLA ELIGIBILITY

- You must have been employed by Marion County for a period of 180 consecutive calendar days immediately preceding the date leave begins, and
- You must have worked an average of 25-hours per week in the above-mentioned timeframe, unless the leave is for Parental Leave in which case there is no hours worked requirement.
- OFLA Military Family Leave: You must have worked an average of 20 hours per week, however there is no 180-day employment requirement.

Qualifying Purposes for FMLA

- Employee's own serious health condition.
- Birth of a child, and to care for a newborn child.
- Placement with employee of a child for adoption or foster care.
- Care for the employee's spouse/registered same gender domestic partner, parent or child with a serious health condition.
- Qualifying Military Exigency Leave arising out of the fact that the employee's spouse, parent or child is on active military duty in the National Guard or Reserve in a "contingency" military operation.
- Service Member Care Leave (SMCL) for a covered service member with a serious injury or illness, if the employee is the spouse, parent or child, or the next of kin of the service member.

Qualifying Purposes for OFLA

- Employee's own serious health condition.
- Parental leave to care for your newborn, newly adopted child or newly placed foster child.
- Care for the employee's spouse/registered same gender domestic partner, parent or child with a serious health condition.
- Sick child leave to care for a child who has a non-serious health condition and requires home care.
- Bereavement leave: Up to two weeks per eligible family member, in a one-ear time period taken within 60 days of notification of the death to attend the funeral or make arrangements necessitated by the death or to grieve.

Family & Medical Leave

NON-SERIOUS SICK CHILD LEAVE (OFLA ONLY)

It's a fact – kids get sick. It's understandable that as parents, you'll sometimes need to stay home and take care of them. You can take leave to care for your child, under the age of 18, with an illness or injury that requires home care but is not serious. You may be required to provide a doctor's note after the fourth time you use this leave. Sick child leave is not for routine medical or dental appointments.

SERIOUS HEALTH CONDITION LEAVE

If you, or an immediate family member you need to care for, have a health condition which requires you to miss work on an intermittent or continuous basis, you may qualify for this type of leave. You will need to go through the Certification of Serious Health Condition process to see if the reason for leave is a qualified reason under FMLA and/or OFLA.

MILITARY FAMILY LEAVE

Military service members, veterans, and their families have protected leave rights. These include:

- caregiver leave for a military service member dealing with a serious illness or injury incurred or aggravated in the line of covered active duty.
- exigency leave to help with needs resulting from a family member's active-duty military service, such as making financial, legal or child or elder care arrangements.

Please contact Human Resources if you have any questions related to military service, military leave, or veteran status.

WHAT IS EXIGENCY LEAVE?

This is 12 work weeks of unpaid, job-protected leave in a 12-month period to make arrangements when a family member is deployed.

BEREAVEMENT LEAVE (OFLA ONLY)

When you lose someone you love, you need time to grieve, be with those closest to you and to make necessary arrangements related to the death and/or to attend the funeral or alternative ceremony. Bereavement leave gives you the chance to take time away to do just that.

Note: If you do not meet eligibility requirements for OFLA, Marion County Personnel Rules authorize an employee to take a maximum of five (5) days, chargeable to any accumulated leave.

HOW MUCH LEAVE CAN I TAKE?

With some exceptions, employees are entitled to 12 weeks within a one-year period. That exhausts the FMLA leave entitlement except for military caregivers leave, which can extend to 26 weeks in one leave year. Under OFLA, women taking any pregnancy disability leave are allowed an additional 12 weeks for any OFLA purpose. Either parent who has taken a full 12 weeks of parental leave (e.g., to care for a newborn, newly adopted child or newly placed foster child) are also entitled to take up to an additional 12 weeks leave to care for a child with a non-serious health condition requiring home care.

For more information about Marion County Protected Leave Programs, please visit: https://intra.co.marion.or.us/HR/Pages/Protected%20Leave.aspx

Retirement Plans

Life happens fast. Are you ready for retirement? Whether your dreams are modest or grand, the freedom to pursue them requires financial security.

A successful retirement means different things to different people. Some people are ready to travel and pursue hobbies and recreation, others want to get involved in their communities or spend more time with people they love.

Social Security benefits are an important source of retirement income but they are usually not enough to comfortably live on during retirement. As an eligible Marion County employee, you are able to participate in the Oregon Public Employees Retirement System (PERS). PERS provides steady retirement income and a solid foundation for a secure retirement. Marion County also offers optional deferred compensation plans that we'll review in the following pages. These plans let you save and invest pretax earnings that can go a long way in helping you meet your retirement goals.

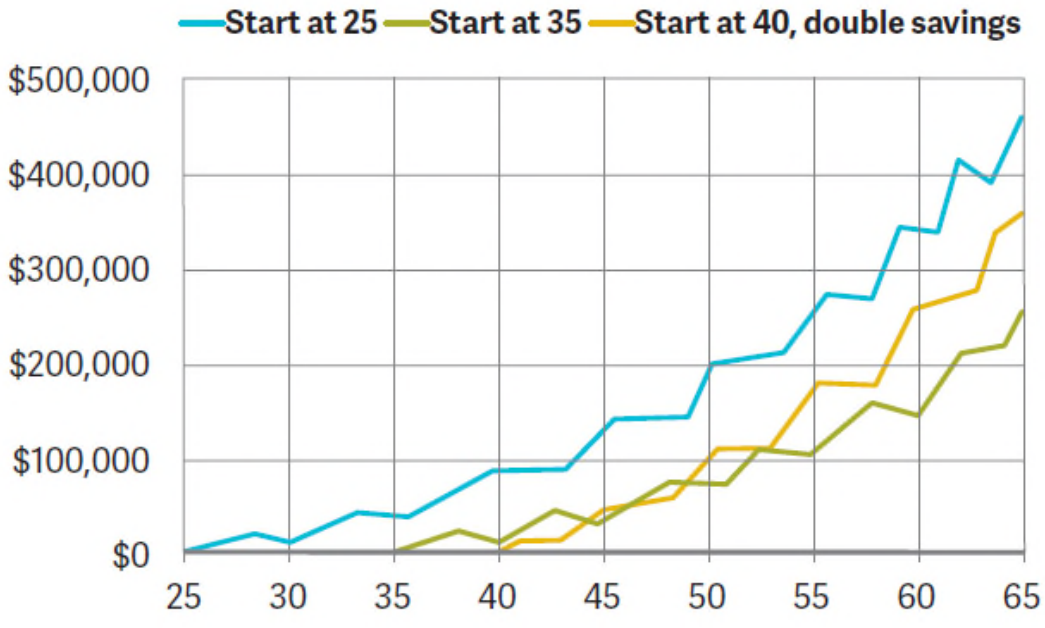
No matter your goals, getting started early will pay later. Saving money can be a challenge in your 20s and 30s when you're focused on establishing your career and family. You can start small. Savings add up and investing them in a deferred compensation plan pretax can make an easy but significant contribution to your future retirement security and independence.

Need a Financial Coach?

Financial coaching, including retirement planning, is available at no cost through Marion County's Canopy Employee Assistance Program.

For more information and support:

- Call: 800-433-2330
- Fax: 503-850-7721
- Email: info@canopywell.com



Pro tip!

One easy way to save without feeling a pinch is to invest some or all of your annual wage increase.

PERS Retirement Benefits

PERS provides steady retirement income that you can't outlive so you can focus on the people and activities you love.

WHO'S ELIGIBLE?

You don't have to apply to participate in the PERS retirement program. Eligibility and contributions are tracked and administered automatically by the payroll department. You are eligible for PERS benefits if you have worked for 6 full months and if you work 600 or more total service hours in a calendar year.

PERS benefits are broken into three tiers. The tiers are based on your date of hire. They also reflect any changes in law about the benefit levels and requirements.

What tier are you in?

- **PERS Tier 1:** If you were hired before Dec. 31, 1995, you are a PERS Tier 1 member.
- **PERS Tier 2:** If you were hired after Jan. 1, 1996 but before Aug. 29, 2003, you are a PERS Tier 2 member.
- **PERS Tier 3:** If you were hired on or after August 29, 2003, you are a part of the Oregon Public Service Retirement Plan (OPSRP).

HOW DO THE BENEFITS WORK?

The PERS pension is an employer-funded retirement benefit. Marion County makes contributions. The funds are invested, and the earnings on the investments generate income for you when you retire. When you retire, the pension pays you a specified amount of money for the rest of your life. The amount you are paid is defined by a formula based on your number of years of service in the pension system, and wage or salary level.

PERS comparison chart

	Tier one	Tier two	OPSRP pension	IAP
Retirement age	58 (or 30 years of service)	60 (or 30 years of service)	65 (58 with 30 years of service)	55
Early retirement	55	55	55	55
Earnings	Guaranteed assumed rate; currently 8% annually	No guarantee; market returns	N/A; no member account	No guarantee; market returns

PERS Retirement Benefits

There are 2 parts to the PERS Retirement Benefit.

PART 1: PENSION*

This part is funded by Marion County. Retirement benefits are based on your years of service and your salary. This is a lifetime benefit and you are vested after 5 years.

PART 2: INDIVIDUAL ACCOUNT PROGRAM (IAP)

This part is funded by Marion County on your behalf. The benefits are based on contributions and account earnings. These benefits will last as long as the money lasts. You are vested after the first contribution.

THE FIRST STEP IS GETTING VESTED

Vesting is the transfer of pension rights to your personal ownership including your share of the pension fund's earnings. To vest in your pension, you must do one of two things:
Work for five years in a PERS-qualifying position for at least 600 hours per year. The years do not need to be consecutive, but you cannot have a gap in qualifying employment of more than five years.
Work in a qualifying position on or after reaching normal retirement age.

Being vested means that you cannot lose your right to your pension benefit unless you withdraw from the overall program.

SOCIAL SECURITY

Your Social Security benefits are determined by a complex formula based on the 35 years of highest earnings over your lifetime, when the earnings occurred, your birth date, and your age at the time payments begin.

Starting benefits before your full retirement age (65 to 67, depending on your year of birth) will reduce the amount of each Social Security payment, although you will get more of them. Waiting until after your full retirement age, up to age 70, will increase your benefit amount. If married, you should also coordinate benefits with your spouse.

To estimate your retirement benefits, visit the Social Security Administration's website at **ssa.gov/myaccount**. Not all public employees quality for Social Security retirement benefits. If you received earnings not covered by Social Security, your estimated benefit may be lower, visit **ssa.gov/benefits**.

HOW MUCH WILL I HAVE IN RETIREMENT?

The PERS plan bases the benefit on your final average salary. In general, this salary figure is calculated as either the average of your highest salaries from three consecutive years or one third of your total salary in the last 36 months of employment.

The PERS formula varies slightly depending on your service type. Most Marion County employees are in general service.

General service formula: 1.5% × years of total retirement credit × final average salary

Example:
Final average salary: $45,000
Retirement credit: 30 years Convert 1.5% for ease of multiplication: 1.5% ÷ 100% = 0.015
0.015 × 30 × $45,000 = $20,250 per year
$20,250 ÷ 12 months = $1,687.50 per month in pension income

This example is based on a Single Life Option. Learn about the various retirement options you will have, including beneficiary options, in the OPSRP Pre-Retirement Guide.

PERS Retirement Benefits

YOUR INDIVIDUAL ACCOUNT

The pension is supplemented with an Individual Account Program (IAP) defined contribution plan. The account is invested and grows over time based on investment returns, and you end up with a pot of money that is yours at retirement.

HOW DOES THE INDIVIDUAL ACCOUNT WORK?

Contributions to your IAP account begin as soon as you officially become a PERS member which is usually after six months of employment. You are vested in your IAP account from its inception.

Your IAP is built with contributions that amount to 6% of your salary. Marion County makes this contribution on your behalf. Part of your contribution is used to fund the pension plan (2.5% for Tier 1 and 2 and .75% for OPSRP members).

Your IAP account contributions are invested in a Target-Date Fund (TDF) based on your age. This is intended to reduce investment risk and volatility. You have the option to change the fund your account is invested in to better match your risk tolerance and savings goals. You can change your target date fund once per year and during the annual Member Choice window, September 1-30.

At retirement, you can take your IAP account funds in a lump sum, roll over, or in a series of installments. You can use the IAP Disbursement Forecaster to estimate your IAP distribution at retirement.

NEED MORE HELP UNDERSTANDING YOUR PERS RETIREMENT BENEFITS?

Sign up for PERS education sessions, which offer you a chance to learn more about OPSRP and ask PERS educators general questions.

Contact Member Services representatives, who can answer specific questions relating to your OPSRP membership.

Sign up for PERS Tier 1 and 2 or OPSRP non-retired member news in GovDelivery to receive email or text alerts.

Social Security

Your Social Security benefits are determined by a complex formula based on the 35 years of highest earnings over your lifetime, when the earnings occurred, your birth date, and your age at the time payments begin.

Starting benefits before your full retirement age (65 to 67, depending on your year of birth) will reduce the amount of each Social Security payment, although you will get more of them. Waiting until after your full retirement age, up to age 70, will increase your benefit amount. If married, you should also coordinate benefits with your spouse.

To estimate your retirement benefits, visit the Social Security Administration's website at **ssa.gov/myaccount**. Not all public employees quality for Social Security retirement benefits. If you received earnings not covered by Social Security, your estimated benefit may be lower, visit **ssa.gov/benefits**.

Medicare

Medicare is the federal insurance health program for people age 65 and older. There are important initial and ongoing decisions to make about benefits. Be sure to consider the costs and options as you think through your retirement plan. Health care is one of the biggest expenses in retirement.

medicare.gov or 1-800-medicare.

Don't forget to fill out your PERS beneficiary form.

To find a form or to learn more about PERS benefits, contact PERS at 503-598-7377 or visit Oregon.gov/PERS.

Additional Retirement Benefits

VOLUNTARY DEFERRED COMPENSATION PLANS

Deferred compensation plans are created to supplement your retirement income. While your pension and Social Security will provide a strong foundation, they are not likely to be enough to ensure a secure financial future. Deferred compensation retirement investments through a 401(K) or 457 plan can make up the difference.

Unlike Social Security and PERS, deferred compensation plans are tax-advantaged retirement accounts that you control directly. You choose whether or not to participate. You are in charge of how much you contribute and you decide how you invest your savings based on your goals and risk tolerance. They also have the advantage of being moveable. If you leave Marion County you can roll your savings into an IRA or other retirement account.
With pretax contributions, money that would otherwise be taxed immediately is invested and all taxes, including on earnings, are deferred until the money is withdrawn.

Marion County offers two deferred compensation retirements savings plan – a 401(K) and a 457. You can contribute into one or both plans. Both plans are administered through Voya Financial.

VOYA FINANCIAL 401(K) PLAN

To be eligible for Marion County's 401(K) plan you must meet certain eligibility requirements. Employee Benefits will contact you once you are eligible. The 401(K) plan offers a traditional pretax contribution election.

VOYA FINANCIAL 457 PLAN

Marion County's 457 plan offers:

- A traditional pretax contribution election
- A Roth 457 plan after-tax election option

For each calendar year employees under age 50 may defer up to $20,500 into their 401(K) and/or 457 plans; employees age 50 and older may defer an additional $6,500 per calendar year. Employees close to retirement may also be permitted to make special catch-up contributions, see your plan for details. You decide how to invest your contributions based on your goals and risk tolerance and determine which Voya Financial funds you want to invest in.

You may enroll or change your 401(K) and 457 plan elections at any time by enrolling online. After you're enrolled, Voya Financial can help you create your goals and enroll in Marion County's plan so you can start saving for your future today! **VoyaRetirementPlans.com**

Ready to enroll? Visit VoyaRetirementPlans.com

After you're enrolled, Wendi Stefani, Financial Advisor, can help you get started. Call her at 503-937-0351.

Contact Information

Benefit	Carrier	Phone #	Web
Medical	PacificSource	877-977-9299	www.pacificsource.com
	Kaiser	800-813-2000, option 1	www.kp.org
Dental	Delta Dental	888-217-2363	www.modahealth.com
	Kaiser	800-813-2000, option 1	www.kp.org
Vision	Contact your medical carrier		
FSA	Navia Benefit Solutions	800-669-3539	www.naviabenefits.com
EAP	Canopy	800-433-2320	www.my.canopywell.com
Retirement	Voya	503-937-0351	www.voyaretirementplans.com
Retirement	PERS	503-598-7377	www.oregon.gov/PERS
HR	Benefits Team	503-584-4700	Mcemployeebenefits@co.marion.or.us

Important Notices

Continuation Coverage Rights Under COBRA

You are receiving this notice because you recently gained coverage under a group health plan Marion County. This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it.** When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

What is COBRA continuation coverage?

COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage are required to pay for their COBRA continuation coverage.

If you're an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you're the spouse of an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because of the following qualifying events:

Important Notices

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a "dependent child."

This information may apply after becoming a retiree:

Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to Marion County, and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee will become a qualified beneficiary. The retired employee's spouse, surviving spouse, and dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

When is COBRA continuation coverage available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after Professional Benefit Services has been notified that a qualifying event has occurred. The employer must notify the Plan Administrator of the following qualifying events:

- The end of employment or reduction of hours of employment;
- Death of the employee;
- Commencement of a proceeding in bankruptcy with respect to the employer; or
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice to: Marion County Employee Benefits staff, by completing a Health Plans Enrollment/Change Form. Additional documentation is required in the event of a divorce. Please contact Employee Benefits staff for further details.

How is COBRA continuation coverage provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

Disability extension of 18-month period of COBRA continuation coverage

Important Notices

If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage. Should this occur, please contact Employee Benefits staff within 30-days of determination.

Second qualifying event extension of 18-month period of continuation coverage

If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

Are there other coverage options besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicare, Medicaid, Children's Health Insurance Program (CHIP) or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

Can I enroll in Medicare instead of COBRA continuation coverage after my group health plan coverage ends?

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period[1] to sign up for Medicare Part A or B, beginning on the earlier of

- The month after your employment ends; or
- The month after group health plan coverage based on current employment ends.

If you don't enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage.

If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare.

For more information visit www.medicare.gov/medicare-and-you.

If you have questions

[1] https://www.medicare.gov/sign-up-change-plans/how-do-i-get-parts-a-b/part-a-part-b-sign-up-periods.

Important Notices

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit **www.dol.gov/ebsa**. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit www.HealthCare.gov.

Keep your Plan informed of address changes

To protect your family's rights, let Marion County and the Plan Administrator know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to Marion County and the Plan Administrator.

Plan contact information

Plan Administrator:	Professional Benefit Services 1193 Royvonne Ave SE #22 Salem, OR 97302 Phone: 503-371-7622
Marion County Contact:	Christopher Collingham, Employee Benefits Specialist Kathie Carter, Sr. Employee Benefits Specilaist Marion County Human Resources 555 Court St NE, Suite #4250 Salem, OR 97301 Email: MCEmployeeBenefits@co.marion.or.us

Important Notices

Important Notice About Your Prescription Drug Coverage and Medicare -

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Marion County and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. Kaiser and PacificSource have determined that the prescription drug coverage offered in our plans is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th through December 7th.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current Marion County coverage will not be affected.

If you do decide to join a Medicare drug plan and drop your current Marion County coverage, be aware that active employees and their dependents who waive this coverage may not be able to get this coverage back until open enrollment or a qualified status change event.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with Marion County and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information About This Notice or Your Current Prescription Drug Coverage...

Contact Human Resources for further information. **NOTE:** You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through Marion County changes. You also may request a copy of this notice at any time.

Important Notices

For More Information About Your Options Under Medicare Prescription Drug Coverage...

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov
- Call your State Health Insurance Assistant Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help.
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

Name of Entity/Sender: Marion County

Newborns' and Mothers' Health Protection Act Notice

Maternity Benefits
Under Federal and state law you have certain rights and protections regarding your maternity benefits under the Plan.

Under federal law known as the **"Newborns' and Mothers' Health Protection Act of 1996" (Newborn's Act)** group health plans and health insurance issuers generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Women's Health & Cancer Rights Act Enrollment Notice

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedemas.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan.

If you would like more information on WHCRA benefits, call Human Resources.

Privacy Notice Reminder

The privacy rules under the Health Insurance Portability and Accountability Act (HIPAA) require the Marion County(the "plan") to periodically send a reminder to participants about the availability of the Plan's Privacy Notice and how to obtain that notice. The Privacy Notice explains participants' rights and the Plan's legal duties with respect to protected health information (PHI) and how the Plan may use and disclose PHI.

To obtain a copy of the Privacy Notice contact Human Resources.

Important Notices

Special Enrollment Rights Notice

Under the special enrollment provisions of HIPAA, you may be eligible, in certain situations, to enroll in a Marion County medical plan during the year, even if you previously declined coverage. This right extends to you and all eligible family members.

You will be eligible to enroll yourself (and eligible dependents) if, during the year you or your dependents have lost coverage under another plan because:

- Coverage ended due to termination of employment, divorce, death, or a reduction in hours that affected benefits eligibility.
- Employer contributions to the plan stopped;
- The plan was terminated;
- COBRA coverage ended; or
- The lifetime maximum for medical benefits was exceeded under the existing medical coverage option.

You must notify the plan within 30 days of the loss of coverage in order to enroll in the Marion County medical plan during the year. Otherwise, you will need to wait until the plan's open enrollment period.

- If you gain a new dependent during the year as a result of birth, adoption or placement for adoption, you may enroll that dependent, as well as yourself and any other eligible dependents, in the plan again, even if you previously declined medical coverage.

You must notify the plan within 60 days of the event in order to enroll in the Marion County medical plan during the year. Otherwise, you will need to wait until the plan's open enrollment period. Coverage will be retroactive to the date of the birth or adoption for children enrolled during the year under these provisions.

Effective April 1, 2009, you will be eligible to enroll yourself and eligible dependents if either of two events occur:

- You or your dependent loses Medicaid or Children's Health Insurance Program (CHIP) coverage because you are no longer eligible.
- You or your dependent qualifies for state assistance in paying your employer group medical plan premiums.

Regardless of other enrollment deadlines, you will have 60 days from the date of the Medicaid/CHIP event to request enrollment in the Marion County medical plan.

Please note that special enrollment rights allow you to either:

- Enroll in your current medical coverage; or
- Enroll in any medical plan benefit option for which you and your dependents are eligible.

Michelle's Law Notice

Michelle's Law is a federal law that requires certain group health plans to continue eligibility for adult dependent children who are students attending a post-secondary school, where the children would otherwise cease to be considered eligible students due to a medically necessary leave of absence from school. In such a case, the plan must continue to treat the child as eligible up to the earlier of:

- The date that is one year following the date the medically necessary leave began; or the date coverage would otherwise terminate under the plan.

For the protections of Michelle's Law to apply, the child must:

- Be a dependent child, under the terms of the plan, of a participant or beneficiary; and have been enrolled in the plan, and as a student at a post-secondary education institution, immediately preceding the first day of the medically necessary leave of absence.
- Medically necessary leave of absence means: Any change in enrollment at the post-secondary school that begins while the child is suffering from a serious illness or injury, is medically necessary, and causes the child to lose student status for purposes of coverage under the plan.

If you believe your child is eligible for this continued eligibility, you must provide to the plan a written certification by his or her treating physician that the child is suffering from a serious illness or injury and that the leave of absence is medically necessary. If you have any questions regarding this information contained in this notice or your child's right to Michelle's Law's continued coverage, you should contact Human Resources.

Important Notices

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs, but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit www.healthcare.gov.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or www.insurekidsnow.gov to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at www.askebsa.dol.gov or call **1-866-444-EBSA (3272)**.

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2021. Contact your State for more information on eligibility –

ALABAMA Medicaid	**CALIFORNIA**
Website: http://myalhipp.com Phone: 1-855-692-5447	Website: Health Insurance Premium Payment (HIPP) Program http://dhcs.ca.gov/hipp Phone: 916-445-8322 Email: hipp@dhcs.ca.gov
ALASKA Medicaid	**COLORADO Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)**
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com	Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: https://www.colorado.gov/pacific/hcpf/child-health-plan-plus CHP+Customer Service: 1-800-359-1991/ State Relay 711
Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx	Health Insurance Buy-In Program (HIBI) https://www.colorado.gov/pacific/hcpf/health-insurance-buy-program HIBI Customer Service: 1-855-692-6442
ARKANSAS	**FLORIDA**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268

Important Notices

GEORGIA	MASSSACHUSETTS
Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp	Website: https://www.mass.gov/info-details/masshealth-premium-assistance-pa
Phone: 678-564-1162 ext. 2131	Phone: 1-800-862-4840
INDIANA	**MINNESOTA**
Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/	Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp
Phone: 1-877-438-4479 All other Medicaid Website: https://www.in.gov/medicaid/	Phone: 1-800-657-3739
Phone: 1-800-457-4584	
IOWA	**MISSOURI**
Medicaid Website: https://dhs.iowa.gov/ime/members	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm
Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki	Phone: 573-751-2005
Hawki Phone: 1-800-257-8563 HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp	
KANSAS	**MONTANA**
Website: https://www.kancare.ks.gov/	Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP
Phone: 1-800-792-4884	Phone: 1-800-694-3084
KENTUCKY	**NEBRASKA**
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx	Website: http://www.ACCESSNebraska.ne.gov
Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov	Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx	
Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov	
LOUISIANA	**NEVADA**
Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp	Medicaid Website: http://dhcfp.nv.gov
Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488	Medicaid Phone: 1-800-992-0900
MAINE	**NEW HAMPSHIRE**
Enrollment Website: https://www.maine.gov/dhhs/ofi/applications-forms	Website: https://www.dhhs.nh.gov/oii/hipp.htm
Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms	Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345 ext. 5218
Phone: 1-800-977-6740 TTY: Maine relay 711	

Important Notices

NEW JERSEY	UTAH
Medicaid Website: http://www.state.nj.us/humanservices//dmahs/clients/medicaid/	Medicaid Website: https://medicaid.utah.gov/
Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html	CHIP Website: http://health.utah.gov/chip
CHIP Phone: 1-800-701-0710	Phone: 1-877-543-7669
OKLAHOMA	**VERMONT**
Website: http://www.insureoklahoma.org	Website: http://www.greenmountaincare.org/
Phone: 1-888-365-3742	Phone: 1-800-250-8427
OREGON	**VIRGINIA**
Website: http://healthcare.oregon.gov/Pages/index.aspx	Website: https://www.coverva.org/en/famis-select
http://www.oregonhealthcare.gov/index-es.html	https://www.coverva.org/en/hipp
Phone: 1-800-699-9075	Medicaid Phone: 1-800-432-59-24 CHIP Phone: 1-800-432-5924
PENNSYLVANIA	**WASHINGTON**
Website: https://www.dhs.pa.gov/providers/Providers/Pages/Medical/HIPP-Program.aspx	Website: https://www.hca.wa.gov/
Phone: 1-800-692-7462	Phone: 1-800-562-3022
RHODE ISLAND	**WEST VIRGINIA**
Website: http://www.eohhs.ri.gov/	Website: http://mywvhipp.com/
Phone: 1-855-697-4347, or 401-462-0311 (Direct Rite Share Line)	Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
NEW YORK	**WISCONSIN**
Website: https://www.health.ny.gov/health_care/medicaid/	Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm
Phone: 1-800-541-2831	Phone: 1-800-362-3002
NORTH CAROLINA	**WYOMING**
Website: https://medicaid.ncdhhs.gov/	Website: https://health.wyo.gov/healthcarefin/Medicaid/programs-and-eligibility/
Phone: 919-855-4100	Phone: 1-800-251-1269
NORTH DAKOTA	
Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/	
Phone: 1-844-854-4825	

To see if any other states have added a premium assistance program since July 31, 2021, or for more information on special enrollment rights, contact either:

US Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
1-866-444-EBSA (3272)

US Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877=267-21323, Menu Option 4, Ext. 61565