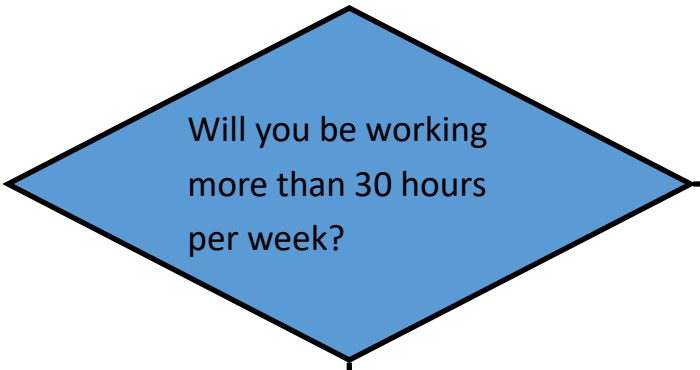

NO

You don't qualify for insurance benefits, but will receive $300 in Employer FSA contribution

YES

You are eligible for insurance coverage.

Chose coverage for each of the following. Click on each for details

Health: choose Kaiser 1, Moda 1, Moda 2, Moda 6, or opting out of insurance.

If you choose Moda 6, you'll receive employer contributions in an HSA.

Dental: choose Kaiser, Delta Dental 1, Delta Dental 5, or Willamette Dental.

Vision: choose Moda Pearl, VSP Choice Plus, or Kaiser.

OCWCOG provides Plan 10 employee and dependent life insurance coverage. Choose if you want to purchase additional coverage. Click this box for pricing details.

OCWCOG provides Plan 11 long-term disability insurance coverage. Choose if you want to purchase additional coverage. Click this box for pricing details.

Once you have made all insurance selections,

log in to the OEBB portal and submit your benefit elections!

If you are either 1) a regular employee (not temporary or intern), working at least 30 hours per week, you chose the Moda 6 health plan, and you are not covered on any other health insurance, including Indian Health Services, Medicare, or Veterans Insurance Benefits; or 2) you didn't qualify for insurance benefits, open an HSA account.

Summary of Medical and Pharmacy Benefits 2022-23 Plan Year

KAISER PERMANENTE®

Plans

Please see Plan Handbook for details.

Monthly premium share charged to OCWCOG employees

Single (no dependents): $9.95
Employee + child(ren): $18.90
Employee + spouse/domestic partner: $21.10
Employee + family: $30.84

No lifetime maximum on any medical plans.	Medical Plan 1 Kaiser Permanente Network		Medical Plan 2A Kaiser Permanente Network		Medical Plan 2B Kaiser Permanente Network		Medical Plan 3 Kaiser Permanente Network	
	In-Network Member Pays	Out-of-Network Member Pays	In-Network Member Pays	Out-of-Network Member Pays	In-Network Member Pays	Out-of-Network Member Pays	In-Network Member Pays	Out-of-Network Member Pays
Deductible per person	None	N/A	$8[illegible]					N/A
Maximum deductible per family	None	N/A	$2,4[illegible]					N/A
Out-of-pocket (OOP) maximum per person	$1,500	N/A	$4,0[illegible]					N/A
Out-of-pocket (OOP) maximum per family	$3,000	N/A	$12,[illegible]					N/A
Preventive Care Services								
Routine adult, well-child and women's exams; annual obesity screening & immunizations.	$0	Not Covered	$0					t Covered
Office Visits and Virtual Care								
Primary care office visits	$20	Not Covered	$2[illegible]					t Covered
Primary care office visits with a provider other than your chosen PCP 360 (Moda Plans only)	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Incentive care office visits (Moda Plans only)	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Virtual Care (Kaiser Plans) / CirrusMD telehealth (Moda Plans)	$0	Not Covered	$0[1]	Not Covered	$0[1]	Not Covered	$0 after deductible	Not Covered
Specialist office visits	$30	Not Covered	$35[1]	Not Covered	$40[1]	Not Covered	20% after deductible	Not Covered
Urgent care	$35	See Plan Handbook	$40[1]	See Plan Handbook	$45[1]	See Plan Handbook	20% after deductible	See Plan Handbook
Mental Health and Chemical Dependency Services								
Mental health office visits	$20	Not Covered	$25[1]	Not Covered	$30[1]	Not Covered	20% after deductible	Not Covered
Mental health inpatient and residential services	$100 per day, up to $500 per admission max	Not Covered	20% after deductible	Not Covered	20% after deductible	Not Covered	20% after deductible	Not Covered
Chemical dependency services (inpatient, outpatient or residential)	$0	Not Covered	$0[1]	Not Covered	$0[1]	Not Covered	20% after deductible	Not Covered
Chemical dependency services (inpatient)	$0	Not Covered	$0[1]	Not Covered	$0[1]	Not Covered	20% after deductible	Not Covered
Outpatient Services								
Outpatient surgery/facility care	$75	Not Covered	20% after deductible	Not Covered	20% after deductible	Not Covered	20% after deductible	Not Covered
Outpatient rehabilitation (physical, occupational & speech therapy)	$30 per visit	Not Covered	$35[1] per visit	Not Covered	$40[1] per visit	Not Covered	20% after deductible	Not Covered
Diagnostic Testing								
Labs, x-ray, and imaging	$20 per visit	Not Covered	$25[1] per visit	Not Covered	$30[1] per visit	Not Covered	20% after deductible	Not Covered
CT, MRI, PET scans	$20 per visit	Not Covered	$25[1] per visit	Not Covered	$30[1] per visit	Not Covered	20% after deductible	Not Covered
Alternative Care Services								
Acupuncture and Chiropractic[7]	$20 per service	Not Covered	$25[1] per service	Not Covered	$30[1] per service	Not Covered	20% after deductible	Not Covered
Naturopathic Office Visits	$20 per service	Not Covered	$25[1] per service	Not Covered	$30[1] per service	Not Covered	20% after deductible	Not Covered
Maternity Care								
Routine maternity care	$0	Not Covered	$0[1]	Not Covered	$0[1]	Not Covered	$0[1]	Not Covered
Physician or midwife services & hospital stay, delivery & routine newborn nursery care	$100 per day, up to $500 per admission max	Not Covered	20% after deductible	Not Covered	20% after deductible	Not Covered	20% after deductible	Not Covered
Hospital Services								
Inpatient care/surgery	$100 per day, up to $500 per admission max	See Plan Handbook	20% after deductible	See Plan Handbook	20% after deductible	See Plan Handbook	20% after deductible	See Plan Handbook
Skilled nursing facility care	$0	N/A	20% after deductible	N/A	20% after deductible	N/A	20% after deductible	N/A

KAISER PERMANENTE®

Plans – *continued*

No lifetime maximum on any medical plans.	Medical Plan 1 Kaiser Permanente Network		Medical Plan 2A Kaiser Permanente Network		Medical Plan 2B Kaiser Permanente Network		Medical Plan 3 Kaiser Permanente Network *HSA Optional*	
	In-Network Member Pays	Out-of-Network Member Pays	In-Network Member Pays	Out-of-Network Member Pays	In-Network Member Pays	Out-of-Network Member Pays	In-Network Member Pays	Out-of-Network Member Pays
Additional Cost Tier								
Moda Plans Only: $100 Additional Cost Tier (ACT): specified imaging (MRI, CT, PET), spinal injections, tonsillectomies for members under age 18 with chronic tonsillitis or sleep apnea, viscosupplementation, upper endoscopies, sleep studies, lumbar discographies	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Moda Plans Only: $500 Additional Cost Tier (ACT): Spine surgery, knee & hip replacement[3], knee & shoulder arthroscopy, uncomplicated hernia repair	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Emergency Services								
Emergency room (copay waived if admitted)	$100 per visit (waived if admitted)		20% after deductible		20% after deductible		20% after deductible	
Ambulance	$75		$100[1]		$100[1]		20% after deductible	
Other Covered Services								
Hearing aids: $4,000 maximum benefit every 48 months for adults, see handbook for State mandated benefit for children	10%	Not Covered	10%[1]	Not Covered	10%[1]	Not Covered	20% after deductible	Not Covered
Durable medical equipment (DME)	20%	Not Covered	20%[1]	Not Covered	20%[1]	Not Covered	20% after deductible	Not Covered
Pharmacy Services								
Out-of-pocket (OOP) maximum	$1100 - Rx max also applies to Medical OOP Max		$1100 - Rx max also applies to Medical OOP Max		$1100 - Rx max also applies to Medical OOP Max		Rx applies toward plan OOP max	
Retail								
Value	N/A	N/A	N/A	N/A	N/A	N/A	$0[7]	N/A
Generic (Kaiser Plans) / Select generic (Moda Plans)	$5 per 30-day supply	See Plan Handbook	$5 per 30-day supply	See Plan Handbook	$5 per 30-day supply	See Plan Handbook	20% after deductible	See Plan Handbook
Preferred brand	$25 per 30-day supply	See Plan Handbook	$25 per 30-day supply	See Plan Handbook	$25 per 30-day supply	See Plan Handbook	20% after deductible	See Plan Handbook
Non-preferred brand[4]	$45 per 30-day supply if criteria met	See Plan Handbook	$45 per 30-day supply if criteria met	See Plan Handbook	$45 per 30-day supply if criteria met	See Plan Handbook	20% after deductible	See Plan Handbook
Mail								
Value	N/A	N/A	N/A	N/A	N/A	N/A		
Generic (Kaiser plans) / Select generic (Moda Plans)	$10 per 90-day supply	See Plan Handbook	$10 per 90-day supply	See Plan Handbook	$10 per 90-day supply	See Plan Handbook	20% after deductible	See Plan Handbook
Preferred Brand	$50 per 90-day supply	See Plan Handbook	$50 per 90-day supply	See Plan Handbook	$50 per 90-day supply	See Plan Handbook	20% after deductible	See Plan Handbook
Non-preferred brand[4]	$90 per 90-day supply if criteria met	See Plan Handbook	$90 per 90-day supply if criteria met	See Plan Handbook	$90 per 90-day supply if criteria met	See Plan Handbook	20% after deductible	See Plan Handbook
Specialty								
Generic (Moda Plans only)	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Select generic (Kaiser plans) / Preferred brand (Moda Plans)	25% up to $100 per 30-day supply	See Plan Handbook	25% up to $100 per 30-day supply	See Plan Handbook	25% up to $100 per 30-day supply	See Plan Handbook	20% after deductible	See Plan Handbook
Non-preferred brand[4]	25% up to $100 per 30-day supply	See Plan Handbook	25% up to $100 per 30-day supply	See Plan Handbook	25% up to $100 per 30-day supply	See Plan Handbook	20% after deductible	See Plan Handbook

N/A – Not applicable

After ded – After deductible

1 Deductible waived.

2 Individual deductible and individual out of pocket maximum apply to single coverage only. Family deductible and family out of pocket maximum apply when two or more individuals are covered on the plan. This plan also includes an embedded per member out-of-pocket max, which is set at the individual OOP amount. Under this plan, deductible must be met before benefits will be paid (except where 1 indicates deductible waived).

3 For Moda plans, OOP maximum includes medical deductible, medical copayments, coinsurance, ACT copayments and pharmacy expenses.

4 A formulary exception must be approved for non-preferred brand prescription medication.

5 To receive in-network coordinated care benefits, you must choose and use a PCP 360.

6 To receive in-network non-coordinated benefits, you must use Connexus providers.

7 For Kaiser plans, acupuncture care is limited to 12 visits per year and chiropractic is limited to 20 visits per year. For Moda plans, acupuncture care and spinal manipulation is limited to 12 combined visits per year. Office visits for acupuncture and chiropractors are subject to the specialist copay and coinsurances and not limited to the 12 combined visits per plan year.

This document is for comparison purposes only and is not intended to fully describe the benefits of each plan. Refer to your member handbook for more details of benefit coverage. In the case of a conflict between this comparison and your member handbook, the member handbook will prevail.

moda HEALTH

Plans 1–4

Please see Plan Handbook for details.

No lifetime maximum on any medical plans.	Medical Plan 1 Connexus Network			Medical Plan 2 Connexus Network								
Plan Year Costs[5]	In-Network Coordinated Care[5] Member Pays	In-Network Non-Coordinated Care[6] Member Pays	Any Out-of-Network Services Member Pays	In-Network Coordinated Care[5] Member Pays	In-Network Non-Coordinated Care[6] Member Pays	Any Out-of-Network Services Member Pays	Coo M					ut-of- work ices r Pays
Deductible per person	$400	$500	$800	$800	$900	$1,600						200
Maximum deductible per family	$1,500	$1,500	$2,400	$2,700	$2,700	$4,800						600
Out-of-pocket (OOP) maximum per person[3]	$2,850	$3,250	$6,000	$3,850	$4,250	$8,000						700
Out-of-pocket (OOP) maximum per family[3]	$9,750	$9,750	$18,000	$12,750	$12,750	$24,000						400
Preventive Care Services												
Routine adult, well-child and women's exams; annual obesity screening & immunizations.	$0[1]	$0[1]	50% after deductible	$0[1]	$0[1]	50% after deductible						after ctible
Office Visits and Virtual Care												
Primary care office visits	$20[1,5]	20% after deductible	50% after deductible	$20[1,5]	20% after deductible	50% after deductible						deductible
Primary care office visits with a provider other than your chosen PCP 360 (Moda Plans only)	$40[1]	N/A	50% after deductible	$40[1]	N/A	50% after deductible						deductible
Incentive care office visits (Moda plans only)	$15[1]	20% after deductible	N/A	$15[1]	20% after deductible	N/A						A
Virtual Care (Kaiser Plans) / CirrusMD telehealth (Moda Plans)	$0[1]	$0[1]	Not covered	$0[1]	$0[1]	Not covered						vered
Specialist office visits	$40[1]	20% after deductible	50% after deductible	$40[1]	20% after deductible	50% after deductible						deductible
Urgent care	$40[1]	20% after deductible	20% after deductible	$40[1]	20% after deductible	20% after deductible						deductible
Mental Health and Chemical Dependency Services												
Mental health office visits	$20[1]	$20[1]	50% after deductible	$20[1]	$20[1]	50% after deductible						deductible
Mental health inpatient and residential services	20% after deductible	20% after deductible	50% after deductible	20% after deductible	20% after deductible	50% after deductible	25%					deductible
Chemical dependency services (outpatient or residential)	$20[1]	$20[1]	50% after deductible	$20[1]	$20[1]	50% after deductible	$25[1]	$25[1]	50% after deductible	$25[1]	$25[1]	50% after deductible
Chemical dependency services (inpatient)	20% after deductible	20% after deductible	50% after deductible	20% after deductible	20% after deductible	50% after deductible	25% after deductible	25% after deductible	50% after deductible	25% after deductible	25% after deductible	50% after deductible
Outpatient Services												
Outpatient surgery/facility care	20% after deductible	20% after deductible	50% after deductible	20% after deductible	20% after deductible	50% after deductible	25% after deductible	25% after deductible	50% after deductible	25% after deductible	25% after deductible	50% after deductible
Outpatient rehabilitation (physical, occupational & speech therapy)	20% after deductible	20% after deductible	50% after deductible	20% after deductible	20% after deductible	50% after deductible	25% after deductible	25% after deductible	50% after deductible	25% after deductible	25% after deductible	50% after deductible
Tests (outpatient)												
Labs, x-ray, and imaging	20% after deductible	20% after deductible	50% after deductible	20% after deductible	20% after deductible	50% after deductible	25% after deductible	25% after deductible	50% after deductible	25% after deductible	25% after deductible	50% after deductible
CT, MRI, PET scans	$100 copay + 20% after deductible	$100 copay + 20% after deductible	$100 copay + 50% after deductible	$100 copay + 20% after deductible	$100 copay + 20% after deductible	$100 copay + 50% after deductible	$100 copay + 25% after deductible	$100 copay + 25% after deductible	$100 copay + 50% after deductible	$100 copay + 25% after deductible	$100 copay + 25% after deductible	$100 copay + 50% after deductible
Alternative Care Services[7]												
Acupuncture and Chiropractic[7]	$20[1]	20% after deductible	20% after deductible	$20[1]	20% after deductible	50% after deductible	$25[1]	25% after deductible	50% after deductible	$25[1]	25% after deductible	50% after deductible
Naturopathic office visits	$40[1]	20% after deductible	50% after deductible	$40[1]	20% after deductible	50% after deductible	$50[1]	25% after deductible	50% after deductible	$50[1]	25% after deductible	50% after deductible
Maternity Care												
Routine maternity care	20% after deductible	20% after deductible	50% after deductible	20% after deductible	20% after deductible	50% after deductible	25% after deductible	25% after deductible	50% after deductible	25% after deductible	25% after deductible	50% after deductible
Physician or midwife services & hospital stay, delivery & routine newborn nursery care	20% after deductible	20% after deductible	50% after deductible	20% after deductible	20% after deductible	50% after deductible	25% after deductible	25% after deductible	50% after deductible	25% after deductible	25% after deductible	50% after deductible
Hospital Services												
Inpatient care/surgery	20% after deductible	20% after deductible	50% after deductible	20% after deductible	20% after deductible	50% after deductible	25% after deductible	25% after deductible	50% after deductible	25% after deductible	25% after deductible	50% after deductible
Skilled nursing facility care	20% after deductible	20% after deductible	50% after deductible	20% after deductible	20% after deductible	50% after deductible	25% after deductible	25% after deductible	50% after deductible	25% after deductible	25% after deductible	50% after deductible

Monthly premium share charged to OCWCOG employees

MODA 1
Single (no dependents): $9.95
Employee + child(ren): $18.90
Employee + spouse/domestic partner: $21.10
Employee + family: $30.84

MODA 2:
Single (no dependents): $0
Employee + child(ren): $0
Employee + spouse/domestic partner: $0
Employee + family: $0

Plans 1–4 – *continued*

No lifetime maximum on any medical plans.	Medical Plan 1 Connexus Network			Medical Plan 2 Connexus Network			Medical Plan 3 Connexus Network			Medical Plan 4 Connexus Network		
Plan Year Costs[5]	In-Network Coordinated Care[5] Member Pays	In-Network Non-Coordinated Care[6] Member Pays	Any Out-of-Network Services Member Pays	In-Network Coordinated Care[5] Member Pays	In-Network Non-Coordinated Care[6] Member Pays	Any Out-of-Network Services Member Pays	In-Network Coordinated Care[5] Member Pays	In-Network Non-Coordinated Care[6] Member Pays	Any Out-of-Network Services Member Pays	In-Network Coordinated Care[5] Member Pays	In-Network Non-Coordinated Care[6] Member Pays	Any Out-of-Network Services Member Pays
Additional Cost Tier												
Moda Plans Only: $100 Additional Cost Tier (ACT): specified imaging (MRI, CT, PET), spinal injections, tonsillectomies for members under age 18 with chronic tonsillitis or sleep apnea, viscosupplementation, upper endoscopies, sleep studies, lumbar discographies	$100 copay + 20% after deductible	$100 copay + 20% after deductible	$100 copay + 50% after deductible	$100 copay + 20% after deductible	$100 copay + 20% after deductible	$100 copay + 50% after deductible	$100 copay + 25% after deductible	$100 copay + 25% after deductible	$100 copay + 50% after deductible	$100 copay + 25% after deductible	$100 copay + 25% after deductible	$100 copay + 50% after deductible
Moda Plans Only: $500 Additional Cost Tier (ACT): Spine surgery, knee & hip replacement, knee & shoulder arthroscopy, uncomplicated hernia repair	$500 copay + 20% after deductible	$500 copay + 20% after deductible	$500 copay + 50% after deductible	$500 copay + 20% after deductible	$500 copay + 20% after deductible	$500 copay + 50% after deductible	$500 copay + 25% after deductible	$500 copay + 25% after deductible	$500 copay + 50% after deductible	$500 copay + 25% after deductible	$500 copay + 25% after deductible	$500 copay + 50% after deductible
Emergency Services												
Emergency room (copay waived if admitted)	$100 copay + 20% after deductible			$100 copay + 20% after deductible			$100 copay + 25% after deductible			$100 copay + 25% after deductible		
Ambulance	20% after deductible			20% after deductible			25% after deductible			25% after deductible		
Other Covered Services												
Hearing aids: $4,000 maximum benefit every 48 months for adults, see handbook for State mandated benefit for children	10% after deductible	10% after deductible	50% after deductible	10% after deductible	10% after deductible	50% after deductible	10% after deductible	10% after deductible	50% after deductible	10% after deductible	10% after deductible	50% after deductible
Durable medical equipment (DME)	20% after deductible	20% after deductible	50% after deductible	20% after deductible	20% after deductible	50% after deductible	25% after deductible	25% after deductible	50% after deductible	25% after deductible	25% after deductible	50% after deductible
Pharmacy Services												
Out-of-pocket (OOP) maximum	Rx applies toward OOP Max			Rx applies toward OOP Max			Rx applies toward OOP Max			Rx applies toward OOP Max		
Retail												
Value	$4 per 31-day supply		See Plan Handbook	$4 per 31-day supply		See Plan Handbook	$4 per 31-day supply		See Plan Handbook	$4 per 31-day supply		See Plan Handbook
Generic (Kaiser Plans) / Select generic (Moda Plans)	$12 per 31-day supply			$12 per 31-day supply			$12 per 31-day supply			$12 per 31-day supply		
Preferred brand	25% up to $75 per 31-day supply			25% up to $75 per 31-day supply			25% up to $75 per 31-day supply			25% up to $75 per 31-day supply		
Non-preferred brand[4]	50% up to $175 per 31-day supply			50% up to $175 per 31-day supply			50% up to $175 per 31-day supply			50% up to $175 per 31-day supply		
Mail												
Value	$8 per 90-day supply		See Plan Handbook	$8 per 90-day supply		See Plan Handbook	$8 per 90-day supply		See Plan Handbook	$8 per 90-day supply		See Plan Handbook
Generic (Kaiser Plans) / Select generic (Moda Plans)	$24 per 90-day supply			$24 per 90-day supply			$24 per 90-day supply			$24 per 90-day supply		
Preferred brand	25% up to $150 per 90-day supply			25% up to $150 per 90-day supply			25% up to $150 per 90-day supply			25% up to $150 per 90-day supply		
Non-preferred brand[4]	50% up to $450 per 90-day supply			50% up to $450 per 90-day supply			50% up to $450 per 90-day supply			50% up to $450 per 90-day supply		
Specialty												
Generic (Moda Plans only)	$12 per 31-day supply or $36 per 90-day supply when allowed		See Plan Handbook	$12 per 31-day supply or $36 per 90-day supply when allowed		See Plan Handbook	$12 per 31-day supply or $36 per 90-day supply when allowed		See Plan Handbook	$12 per 31-day supply or $36 per 90-day supply when allowed		See Plan Handbook
Select generic (Kaiser plans) / Preferred brand (Moda Plans)	25% up to $200 per 31-day supply or $400 for 90-day supply when allowed			25% up to $200 per 31-day supply or $400 for 90-day supply when allowed			25% up to $200 per 31-day supply or $400 for 90-day supply when allowed			25% up to $200 per 31-day supply or $400 for 90-day supply when allowed		
Non-preferred brand[4]	50% up to $500 per 31-day supply or $1,000 for 90-day supply when allowed.			50% up to $500 per 31-day supply or $1,000 for 90-day supply when allowed.			50% up to $500 per 31-day supply or $1,000 for 90-day supply when allowed.			50% up to $500 per 31-day supply or $1,000 for 90-day supply when allowed.		

N/A – Not applicable

After ded – After deductible

1 Deductible waived.

2 Individual deductible and individual out of pocket maximum apply to single coverage only. Family deductible and family out of pocket maximum apply when two or more individuals are covered on the plan. This plan also includes an embedded per member out-of-pocket max, which is set at the individual OOP amount. Under this plan, deductible must be met before benefits will be paid (except where 1 indicates deductible waived).

3 For Moda plans, OOP maximum includes medical deductible, medical copayments, coinsurance, ACT copayments and pharmacy expenses.

4 A formulary exception must be approved for non-preferred brand prescription medication.

5 To receive in-network coordinated care benefits, you must choose and use a PCP 360.

6 To receive in-network non-coordinated benefits, you must use Connexus providers.

7 For Kaiser plans, acupuncture care is limited to 12 visits per year and chiropractic is limited to 20 visits per year. For Moda plans, acupuncture care and spinal manipulation is limited to 12 combined visits per year. Office visits for acupuncture and chiropractors are subject to the specialist copay and coinsurances and not limited to the 12 combined visits per plan year.

This document is for comparison purposes only and is not intended to fully describe the benefits of each plan. Refer to your member handbook for more details of benefit coverage. In the case of a conflict between this comparison and your member handbook, the member handbook will prevail.

Plans 5–7

No lifetime maximum on any medical plans.	Medical Plan 5 Connexus Network			Medical Plan 6 Connexus Network *HDHP HSA Compliant*			Medical Plan 7 Connexus Network *HDHP HSA Compliant*		
Plan Year Costs - Deductibles and copayments apply to the annual out-of-pocket maximum.	In-Network Coordinated Care[5] Member Pays	In-Network Non-Coordinated Care[6] Member Pays	Any Out-of-Network Services Member Pays	In-Network Coordinated Care[5] Member Pays	In-Network Non-Coordinated Care[6] Member Pays	Any Out-of-Network Services Member Pays			
Deductible per person	$2,000	$2,100	$4,000	$1,600[2]	$1,700[2]	$3,200[2]			
Maximum deductible per family	$6,300	$6,300	$12,600	$3,400[2]	$3,400[2]	$6,400[2]			
Out-of-pocket (OOP) maximum per person[3]	$6,800	$7,200	$13,700	$6,400[2]	$6,750[2]	$13,100[2]			
Out-of-pocket (OOP) maximum per family[3]	$15,800	$15,800	$27,400	$13,500[2]	$13,500[2]	$26,200[2]			
Preventive Care Services									
Routine adult, well-child and women's exams; annual obesity screening & immunizations.	$0[1]	$0[1]	50% after deductible	$0[1]	$0[1]	50% after deductible			
Office Visits and Virtual Care									
Primary care office visits	$30[1,5]	25% after deductible	50% after deductible	15% after deductible	20% after deductible	50% after deductible			
Primary care office visits with a provider other than your chosen PCP 360 (Moda Plans only)	$50[1]	N/A	50% after deductible	15% after deductible	N/A	50% after deductible			
Incentive care office visits (Moda plans only)	$25[1]	25% after deductible	N/A	15% after deductible	20% after deductible	N/A			
Virtual Care (Kaiser Plans) / CirrusMD telehealth (Moda Plans)	$0[1]	$0[1]	Not covered	$0 after deductible	$0 after deductible	Not covered			
Specialist office visits	$50[1]	25% after deductible	50% after deductible	15% after deductible	20% after deductible	50% after deductible			
Urgent care	$50[1]	25% after deductible	25% after deductible	15% after deductible	20% after deductible	See Plan Handbook			
Mental Health Services									
Mental health office visits	$30[1]	$30[1]	50% after deductible	15% after deductible	20% after deductible	50% after deductible			
Mental health inpatient and residential services	25% after deductible	25% after deductible	50% after deductible	20% after deductible	25% after deductible	50% after deductible			
Chemical dependency services (outpatient or residential)	$30[1]	$30[1]	50% after deductible	15% after deductible	20% after deductible	50% after deductible			
Chemical dependency services (inpatient)	25% after deductible	25% after deductible	50% after deductible	20% after deductible	25% after deductible	50% after deductible			
Outpatient Services									
Outpatient surgery/facility care	25% after deductible	25% after deductible	50% after deductible	20% after deductible	25% after deductible	50% after deductible			
Outpatient rehabilitation (physical, occupational & speech therapy)	25% after deductible	25% after deductible	50% after deductible	20% after deductible	25% after deductible	50% after deductible			
Diagnostic Testing									
Labs, x-ray, and imaging	25% after deductible	25% after deductible	50% after deductible	20% after deductible	25% after deductible	50% after deductible	20% after deductible	25% after deductible	50% after deductible
CT, MRI, PET scans	$100 copay + 25% after deductible	$100 copay + 25% after deductible	$100 copay + 50% after deductible	20% after deductible	25% after deductible	50% after deductible	20% after deductible	25% after deductible	50% after deductible
Alternative Care Services									
Acupuncture and Chiropractic[7]	$30[1]	25% after deductible	50% after deductible	20% after deductible	25% after deductible	50% after deductible	20% after deductible	25% after deductible	50% after deductible
Naturopathic Services	$50[1]	25% after deductible	50% after deductible	15% after deductible	20% after deductible	50% after deductible	20% after deductible	25% after deductible	50% after deductible
Maternity Care									
Outpatient maternity care	25% after deductible	25% after deductible	50% after deductible	20% after deductible	25% after deductible	50% after deductible	20% after deductible	25% after deductible	50% after deductible
Physician or midwife services & hospital stay, delivery & routine newborn nursery care	25% after deductible	25% after deductible	50% after deductible	20% after deductible	25% after deductible	50% after deductible	20% after deductible	25% after deductible	50% after deductible
Hospital Services									
Inpatient care/surgery	25% after deductible	25% after deductible	50% after deductible	20% after deductible	25% after deductible	50% after deductible	20% after deductible	25% after deductible	50% after deductible
Skilled nursing facility care	25% after deductible	25% after deductible	50% after deductible	20% after deductible	25% after deductible	50% after deductible	20% after deductible	25% after deductible	50% after deductible
Additional Cost Tier									
Moda Plans Only: $100 Additional Cost Tier (ACT): specified imaging (MRI, CT, PET), spinal injections, tonsillectomies for members under age 18 with chronic tonsillitis or sleep apnea, viscosupplementation, upper endoscopies, sleep studies, lumbar discographies	$100 copay + 25% after deductible	$100 copay + 25% after deductible	$100 copay + 50% after deductible	20% after deductible	25% after deductible	50% after deductible	20% after deductible	25% after deductible	50% after deductible
Moda Plans Only: $500 Additional Cost Tier (ACT): Spine surgery, knee & hip replacement, knee & shoulder arthroscopy, uncomplicated hernia repair	$500 copay + 25% after deductible	$500 copay + 25% after deductible	$500 copay + 50% after deductible	20% after deductible	25% after deductible	50% after deductible	20% after deductible	25% after deductible	50% after deductible

Monthly premium share charged to OCWCOG employees

Single (no dependents): $0
Employee + child(ren): $0
Employee + spouse/domestic partner: $0
Employee + family: $0

Plans 5–7 – *continued*

No lifetime maximum on any medical plans.	**Medical Plan 5 Connexus Network**			**Medical Plan 6 Connexus Network *HDHP HSA Compliant***			**Medical Plan 7 Connexus Network *HDHP HSA Compliant***		
Plan Year Costs - Deductibles and copayments apply to the annual out-of-pocket maximum.	In-Network Coordinated Care[5] Member Pays	In-Network Non-Coordinated Care[6] Member Pays	Any Out-of-Network Services Member Pays	In-Network Coordinated Care[5] Member Pays	In-Network Non-Coordinated Care[6] Member Pays	Any Out-of-Network Services Member Pays	In-Network Coordinated Care[5] Member Pays	In-Network Non-Coordinated Care[6] Member Pays	Any Out-of-Network Services Member Pays
Emergency Services									
Emergency room (copay waived if admitted)	$100 copay + 25% after deductible			20% after deductible	25% after deductible	See Plan Handbook	20% after deductible	25% after deductible	See Plan Handbook
Ambulance	25% after deductible			20% after deductible	25% after deductible	See Plan Handbook	20% after deductible	25% after deductible	See Plan Handbook
Other Covered Services									
Hearing aids: $4,000 maximum benefit every 48 months for adults, see handbook for State mandated benefit for children	10% after deductible	10% after deductible	50% after deductible	20% after deductible	25% after deductible	50% after deductible	20% after deductible	25% after deductible	50% after deductible
Durable medical equipment (DME)	25% after deductible	25% after deductible	50% after deductible	20% after deductible	25% after deductible	50% after deductible	20% after deductible	25% after deductible	50% after deductible
Pharmacy Services									
Out-of-pocket (OOP) maximum	Rx applies toward OOP max			Rx applies toward plan OOP max			Rx applies toward plan OOP max		
Retail									
Value	$4 per 31-day supply		See Plan Handbook	$4[1] per 31-day supply		See Plan Handbook	$4[1] per 31-day supply		See Plan Handbook
Generic (Kaiser Plans) / Select generic (Moda Plans)	$12 per 31-day supply			20% after deductible	25% after deductible		20% after deductible	25% after deductible	
Preferred brand	25% up to $75 per 31-day supply			20% after deductible	25% after deductible		20% after deductible	25% after deductible	
Non-preferred brand[5]	50% up to $175 per 31-day supply			20% after deductible	25% after deductible		20% after deductible	25% after deductible	
Mail									
Value	$8 per 90-day supply		See Plan Handbook	$8[1] per 90-day supply		See Plan Handbook	$8[1] per 90-day supply		See Plan Handbook
Generic (Kaiser Plans) / Select generic (Moda Plans)	$24 per 90-day supply			20% after deductible	25% after deductible		20% after deductible	25% after deductible	
Preferred brand	25% up to $150 per 90-day supply			20% after deductible	25% after deductible		20% after deductible	25% after deductible	
Non-preferred brand[4]	50% up to $450 per 90-day supply			20% after deductible	25% after deductible		20% after deductible	25% after deductible	
Specialty									
Generic (Moda Plans only)	$12 per 31-day supply or $36 per 90-day supply when allowed		See Plan Handbook	20% after deductible	25% after deductible	See Plan Handbook	20% after deductible	25% after deductible	See Plan Handbook
Select generic (Kaiser plans) / Preferred brand (Moda Plans)	25% up to $200 per 31-day supply or $400 for 90-day supply when allowed			20% after deductible	25% after deductible		20% after deductible	25% after deductible	
Non-preferred brand[4]	50% up to $500 per 31-day supply or $1,000 for 90-day supply when allowed.			20% after deductible	25% after deductible		20% after deductible	25% after deductible	

N/A – Not applicable

After ded – After deductible

1 Deductible waived.

2 Individual deductible and individual out of pocket maximum apply to single coverage only. Family deductible and family out of pocket maximum apply when two or more individuals are covered on the plan. This plan also includes an embedded per member out-of-pocket max, which is set at the individual OOP amount. Under this plan, deductible must be met before benefits will be paid (except where 1 indicates deductible waived).

3 For Moda plans, OOP maximum includes medical deductible, medical copayments, coinsurance, ACT copayments and pharmacy expenses.

4 A formulary exception must be approved for non-preferred brand prescription medication.

5 To receive in-network coordinated care benefits, you must choose and use a PCP 360.

6 To receive in-network non-coordinated benefits, you must use Connexus providers.

7 For Kaiser plans, acupuncture care is limited to 12 visits per year and chiropractic is limited to 20 visits per year. For Moda plans, acupuncture care and spinal manipulation is limited to 12 combined visits per year. Office visits for acupuncture and chiropractors are subject to the specialist copay and coinsurances and not limited to the 12 combined visits per plan year.

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Summary of Dental Benefits 2022-23 Plan Year

Please see Plan Handbook for details.

Dental	Premier Plan 1[1]	Premier Plan 5[1]	Premier Plan Ω	Exclusive PPO - Incentive Plan	Exclusive PPO Plan Ω	Kaiser Dental Plan	Willamette Dental Plan
Network	Delta Dental Premier	Delta Dental Premier	Delta Dental		rk Plan – Delta l PPO[2]	Limited Network Plan – Kaiser Permanente Facilities[2]	Limited Network Plan – Willamette Dental Group Facilities[2]
Dental Office Visit Copayment	N/A	N/A	N/A		/A	$20[3]	$20[3]
Benefit Maximum	$2,200[4]	$1,700[4]	$1,2		500[4]	$4,000[4]	N/A
Deductible	$50	$50	$5		50	N/A	N/A
Preventive & Diagnostic Services – Deductible Waived for Preventive & Diagnostic Services on Delta Dental Plans[6]							
Oral exams, X-rays, cleaning (prophylaxis), fluoride treatments, and space maintainers	70% + 10% each Plan Year[6]	70% + 10% each Plan Year[6]	100		0%[6]	100%[6]	100%
Restorative Services							
Routine fillings, inlays and stainless steel crowns	70% + 10%[1] each Plan Year	70% + 10%[1] each Plan Year	80%		0%[1]	100%[3]	100%[3]
Simple Extraction							
Simple tooth extractions	70% + 10% each Plan Year	70% + 10% each Plan Year	80%	70% + 10% each Plan Year	90%	100%[3]	100%[3]
Oral Surgery							
Surgical tooth extractions, including diagnosis and evaluation	70% + 10% each Plan Year	70% + 10% each Plan Year	80%	70% + 10% each Plan Year	90%	$50 Copay[3]	$50 Copay[3]
Periodontics							
Diagnosis, evaluation, and treatment of gum disease including scaling and root planing	70% + 10% each Plan Year	70% + 10% each Plan Year	80%	70% + 10% each Plan Year	90%	100%[3]	100%[3]
Endodontics							
Root canal and related therapy including diagnosis and evaluation	70% + 10% each Plan Year	70% + 10% each Plan Year	80%	70% + 10% each Plan Year	90%	$50 Copay[3]	$50 Copay[3]
Major Restorative Services							
Gold or porcelain crowns and onlays	70% + 10% each Plan Year	70%	50%	70% + 10% each Plan Year	80%	$250 Copay[3]	$250 Copay[3]
Implants	70% + 10% each Plan Year	50%	50%	70% + 10% each Plan Year	80%	50%[3] (limit of 4 per lifetime)	Implant surgery up to $1,500 calendar year maximum
Other covered services							
Occlusal guards (night guards)	50% up to $250 max, once every 5 years	50% up to $250 max, once every 5 years	50% up to $250 max, once every 5 years	50% up to $250 max, once every 5 years	50% up to $250 max, once every 5 years	90%, once every 5 years	100% once every 2 years
Athletic mouth guards	50%	50%	50%	50%	50%	90%	$100 Copay[3]
Nitrous Oxide	50%	50%	50%	50%	50%	$0 copay (Age 12 & Under) $25 copay (Age 13 & Up)	$15 Copay[3]
Fixed and Removable Prosthetic Services							
Full and partial dentures, relines, rebases	70% + 10% each Plan Year	50%	50%	70% + 10% each Plan Year	80%	$100 Copay[3]	$100 Copay[3]
Bridge retainers and pontics	70% + 10% each Plan Year	50%	50%	70% + 10% each Plan Year	80%	$250 Copay[3]	$250 Copay[3]
Orthodontics							
Orthodontic Treatment	80% to $1,800 lifetime max	80% to $1,800 lifetime max	NO ORTHO COVERAGE on this plan	80% to $1,800 lifetime max	80% to $1,800 lifetime max	$2,500 Copay + $20 per visit	$2,500 Copay + $20 per visit

There is no monthly premium share charged to OCWCOG employees for dental coverage.

1 Under Delta Dental Plans 1 and 5, and Exclusive PPO - Incentive Plan benefits start at 70% the first plan year then increase by 10% each plan year (up to a maximum of 100%) provided the individual has visited the dentist at least once during the previous plan year.

2 Services performed by providers outside the limited network are not covered unless for a dental emergency.

3 Office visit copayment applies at each visit, in addition to any plan copayments for services.

4 Preventive care and orthodontia do not accrue to this maximum.

5 Dental implant-supported prosthetics (crowns, bridges, and dentures) are not a covered benefit under the Willamette Dental Group plan.

6 Preventive services will not accrue towards the plan benefit maximum.

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Summary of Vision Benefits 2022-23 Plan Year

There is no monthly premium share charged to OCWCOG employees for vision coverage.

Dental	Kaiser Vision Plan[1] Kaiser Permanente Facilities	Moda Opal Plan May use any licensed provider	Moda Pearl Plan May use any licensed provider	Moda Quartz Plan May use any licensed provider	VSP Choice Plus Plan VSP Choice Network	
Plan Year Maximum	$250	$600	$400	$250	N/A	
Routine Eye Exam:						
Benefit:	Covered under the Kaiser Permanente medical plan (does not apply to the vision plan year maximum)	Plan pays 100% (up to plan maximum)	Plan pays 100% (up to plan maximum)	Plan pays 100% (up to plan maximum)	Plan pays 100% after $10 copay	
Frequency:	As needed	Once per Plan Year	Once per Plan Year	Once per Plan Year	Once every 12 months	Once every 12 months
Lenses:						
Basic lens benefit:	**Under age 19:** No charge for one pair of standard frames and lenses or contacts **Age 19+:** Plan pays 100% (up to plan maximum)	Plan pays 100% (up to plan maximum)	Plan pays 100% (up to plan maximum)	Plan pays 100% (up to plan maximum)	$20 copay (applied towards lenses & frame): Glass or plastic single vision, lined bifocal, lined trifocal, or lenticular lenses covered in full. Polycarbonate lenses, scratch resistant and UV coatings covered in full	$20 copay (applied towards lenses & frame): Glass or plastic single vision, lined bifocal, lined trifocal, or lenticular lenses covered in full. Scratch resistant and UV coatings covered in full
Lens enhancements:					$0 copay for standard progressive lenses $15 copay for anti-reflective coating or premium/custom progressive lenses	$0 copay for standard progressive lenses Discounts for polycarbonate, anti-reflective coating or premium/custom progressive lenses
Frequency:	Once per Plan Year	Once per Plan Year	Once per Plan Year	Once per Plan Year	Once every 12 months	Once every 12 months
Frames / Contacts:						
Benefit:	**Under age 19:** No charge for one pair of standard frames and lenses or contacts **Age 19+:** Plan pays 100% (up to plan maximum)	Plan pays 100% (up to plan maximum)	Plan pays 100% (up to plan maximum)	Plan pays 100% (up to plan maximum)	Covered in full up to retail allowance of **$300;** 20% off amount over retail allowance for frames	Covered in full up to retail allowance of **$150;** 20% off amount over retail allowance for frames
Frequency:	**Frames or Contacts:** Once per Plan Year	**Frames:** *Age 0-16:* Once per Plan Year *Age 17+:* Once every two Plan Years **or Contacts:** Up to the plan maximum	**Frames:** *Age 0-16:* Once per Plan Year *Age 17+:* Once every two Plan Years **or Contacts:** Up to the plan maximum	**Frames:** *Age 0-16:* Once per Plan Year *Age 17+:* Once every two Plan Years **or Contacts:** Up to the plan maximum	**Frames or Contacts:** Once every 12 months	**Frames or Contacts:** Once every 12 months
Non-Prescription Benefit						
Benefit:	$100 of your annual $250 allowance may be used toward non-prescription sunglasses and/or digital eye strain glasses.	Not Covered	Not Covered	Not Covered	OEBB members can use their frame allowance to pay for ready-made non-prescription sunglasses or ready-made non-prescription blue light filtering glasses, in lieu of prescription glasses or contacts.	OEBB members can use their frame allowance to pay for ready-made non-prescription sunglasses or ready-made non-prescription blue light filtering glasses, in lieu of prescription glasses or contacts.

1 Must be enrolled in a Kaiser Medical Plan to enroll in the Kaiser Vision Plan

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You can get this document in other languages, large print, braille or a format you prefer. Contact OEBB Member Services at 888-4My-OEBB (888-469-6322) or email oebb.benefits@state.or.us. We accept all relay calls or you can dial 711.

MSC 3707 (05/31/2022)

Member Services
1-888-469-6322
OEBB.Benefits@state.or.us

The Standard
Basic Life Insurance Plans and Rates
2022-23 Plan Year

Basic Life Plans and Rates		
Plan Design	**Benefit Level**	**Monthly Rate Per Each $1,000 of Benefit**
Plan 1	$5,000.00	$0.088
Plan 2	$7,500.00	$0.088
Plan 3	$10,000.00	$0.088
Plan 4	$15,000.00	$0.088
Plan 5	$20,000.00	$0.088
Plan 6	$25,000.00	$0.088
Plan 7	$30,000.00	$0.088
Plan 8	$35,000.00	$0.088
Plan 9	$40,000.00	$0.088
Plan 10	$50,000.00	$0.088
Plan 11		
Plan 12		
Plan 13		
Plan 14		
Plan 15		
Plan 16	2	
Plan 17	3	
Plan 18		

OCWCOG provides $50,000 employee life coverage and $2,000 dependent life coverage.

Employees may purchase additional coverage available at the rates on the following page.

Basic Dependent Life Plans and Rates $2,000 or $5,000 Maximum Benefit	
Monthly Rate for $2,000 of Benefit	$0.500
Monthly Rate for $5,000 of Benefit	$1.250

Member Services
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The Standard
Optional Life Insurance Plans and Rates
2022-23 Plan Year

Optional Employee Life Plans and Rates $10,000 - $500,000 Maximum Benefit		
Age as of Each October 1st	**Monthly Rate Per Each $10,000 of Benefit**	
	If employee HAS NOT used tobacco in the past 12 months	**If employee HAS used tobacco in the past 12 months**
Under 25	$0.150	$0.230
25 – 29	$0.170	$0.270
30 – 34	$0.190	$0.360
35 – 39	$0.270	$0.410
40 – 44	$0.380	$0.550
45 – 49	$0.580	$0.810
50 – 54	$0.880	$1.240
55 – 59	$1.650	$2.270
60 – 64	$2.520	$3.460
65 – 69	$4.860	$6.510
70 – 74	$5.660	$9.270
75+	$7.880	$10.100

Optional Spouse Life Plans and Rates $10,000 - $500,000 Maximum Benefit		
Age as of Each October 1st	**Monthly Rate Per Each $10,000 of Benefit**	
	If spouse HAS NOT used tobacco in the past 12 months	**If spouse HAS used tobacco in the past 12 months**
Under 25	$0.380	$0.540
25 – 29	$0.450	$0.640
30 – 34	$0.600	$0.860
35 – 39	$0.680	$0.980
40 – 44	$0.800	$1.190
45 – 49	$1.200	$1.820
50 – 54	$1.840	$2.670
55 – 59	$3.400	$4.700
60 – 64	$5.140	$7.040
65 – 69	$9.820	$13.170
70 – 74	$11.770	$16.480
75+	$16.480	$34.830

Optional Child Life Plan and Rate $2,000 - $10,000 Maximum Benefit	
Monthly Rate for $2,000 of Benefit	$0.100

Member Services
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OEBB.Benefits@state.or.us

The Standard
Long Term Disability Plans and Rates
2022-23 Plan Year

VOLUNTARY ENROLLMENT - EMPLOYEE PAID PLANS
Allows each employee to choose whether or not they wish to enroll.
Premiums must be paid by the employee.

	Voluntary Enrollment - Employee Paid					
	Plan 1	Plan 2	Plan 3	Plan 4	Plan 5	Plan 6
Benefit Waiting Period (Days)	60	60	60	90	90	90
Maximum Monthly Benefit	$8,000	$8,000	$8,000	$8,000	$8,000	$8,000
Benefit Percentage	50%	60%	66 ⅔%	50%	60%	66 ⅔%
Monthly Premium = Employee's Average Monthly Wage Multipled By This Rate (Not to exceed Maximum Monthly Pre-disability Earnings*)	0.00309	0.00415	0.00521	0.00247	0.00335	0.00415

MANDATORY ENROLLMENT - EMPLOYER PAID PLANS
Requires all employees to enroll. Premiums must be paid by the employer.

		Paid	
	0	Plan 11	Plan 12
Benefit Waiting Period (Days)		90	90
Maximum Monthly Benefit	0	$8,000	$8,000
Benefit Percentage		60%	66 ⅔%
Monthly Premium = Employee's Average Monthly Wage Multipled By This Rate (Not to exceed Maximum Monthly Pre-disability Earnings*)	5	0.00235	0.00318

OCWCOG provides Plan 11 long term disability coverage.

Employees may purchase additional coverage available at rates on this page and the next.

MANDATORY ENROLLMENT - EMPLOYEE PAID PLANS
Requires all employees to enroll. Premiums must be paid by the employee.

	Mandatory Enrollment - Employee Paid					
	Plan 13	Plan 14	Plan 15	Plan 16	Plan 17	Plan 18
Benefit Waiting Period (Days)	60	60	60	90	90	90
Maximum Monthly Benefit	$8,000	$8,000	$8,000	$8,000	$8,000	$8,000
Benefit Percentage	50%	60%	66 ⅔%	50%	60%	66 ⅔%
Monthly Premium = Employee's Average Monthly Wage Multipled By This Rate (Not to exceed Maximum Monthly Pre-disability Earnings*)	0.00247	0.00327	0.00415	0.00194	0.00265	0.00335

*** Maximum Monthly Pre-disability Earnings:**
For 50% Plan: The first $16,000 of employee's monthly pre-disability earnings
For 60% Plan: The first $13,333 of employee's monthly pre-disability earnings
For 66 ⅔% Plan: The first $12,000 of employee's monthly pre-disability earnings

Member Services
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OEBB.Benefits@state.or.us

MANDATORY ENROLLMENT - EMPLOYER PAID PLANS

Requires all employees to enroll. Premiums must be paid by the employer.

	Mandatory Enrollment - Employer Paid			
	Plan 19	Plan 20	Plan 21	Plan 22
Benefit Waiting Period (Days)	90	90	90	90
Maximum Monthly Benefit	$2,000	$3,000	$4,000	$6,000
Benefit Percentage	66 ⅔%	66 ⅔%	66 ⅔%	66 ⅔%
Monthly Premium = Employee's Average Monthly Wage Multipled By This Rate (Not to exceed Maximum Monthly Pre-disability Earnings**)	0.00295	0.00306	0.00311	0.00318

MANDATORY ENROLLMENT - EMPLOYEE PAID PLANS

Requires all employees to enroll. Premiums must be paid by the employee.

	Mandatory Enrollment - Employee Paid	
	Plan 23	Plan 24
Benefit Waiting Period (Days)	90	90
Maximum Monthly Benefit	$2,000	$3,000
Benefit Percentage	66 ⅔%	66 ⅔%
Monthly Premium = Employee's Average Monthly Wage Multipled By This Rate (Not to exceed Maximum Monthly Pre-disability Earnings**)	0.00300	0.00314

**** Maximum Monthly Pre-disability Earnings:**

For $2,000 plan: The first $3,000 of employee's monthly predisability earnings
For $3,000 plan: The first $4,500 of employee's monthly predisability earnings
For $4,000 plan: The first $6,000 of employee's monthly predisability earnings
For $6,000 plan: The first $9,000 of employee's monthly predisability earnings

VOLUNTARY ENROLLMENT - EMPLOYEE PAID PLANS

Allows each employee to choose whether or not they wish to enroll.
Premiums must be paid by the employee.

	Voluntary Enrollment - Employee Paid	
	Plan 27	Plan 28
Benefit Waiting Period (Days)	180	180
Maximum Monthly Benefit	$8,000	$8,000
Benefit Percentage	50%	60%
Monthly Premium = Employee's Average Monthly Wage Multipled By This Rate (Not to exceed Maximum Monthly Pre-disability Earnings*)	0.00180	0.00255