

Selection Sheet for PEBB Insurance Deductions - Klickitat County

Full Time - Effective January 1, 2023 premiums reflected on your Dec. 25th payroll check

www.hca.wa.gov/pebb

Print Last Name:					Emp No:		
Signature:					Date:		
<i>I hereby authorize the deductions below and acknowledge that I have been informed of my COBRA rights.</i>							
County contributes 100% for Employee Medical, Dental, Vision, Life Insurance & LTD & 70% of the Additional Cost for Dependent Medical, Dental, Vision, Life Ins & LTD Coverage (County Pays an Avg of 86% for Dep)							
C h e c k (X) O n e P l a n	CLASSIC MEDICAL & VISION PLANS \$250 ind/\$750 fam ded, \$2000 ind/\$4000 fam out of pocket max, 15% office visit co-pay, 15%/40% hospital co-insurance 5%/10%/100 ded/30%/50%, \$2000 OOP, Prescription Vision: No co-pay on annual exam, \$150 hardware every 24 months			Uniform Medical Plan (UMP) - Classic Premium <u>Includes:</u> Dental, Vision, Life Insurance & EE LTD Coverage - Administered by Regence		MARK ONE (X)	Ded Code
	EMPLOYEE	970.10	970.10	0.00		300-1	
	EMPLOYEE & SPOUSE	1,782.52	1,538.79	243.73		300-2	
	EMPLOYEE & CHILDREN	1,579.42	1,396.62	182.80		300-3	
	EMPLOYEE & FAMILY	2,391.84	1,965.32	426.52		300-4	
	SELECT MEDICAL & VISION PLANS \$750 ind/\$2250 fam ded, \$3500 ind/\$7000 fam out of pocket max, 20% office visit co-pay, 15%/40% hospital co-insurance 5%/10%/100 ded/30%/50%, \$2000 OOP, Prescription Vision: No co-pay on annual exam, \$150 hardware every 24 months			Uniform Medical Plan (UMP) - Select Premium <u>Includes:</u> Dental, Vision, Life Insurance & EE LTD Coverage - Administered by Regence		MARK ONE (X)	Ded Code
	EMPLOYEE	893.87	893.87	0.00		303-1	
	EMPLOYEE & SPOUSE	1,630.06	1,538.79	91.27		303-2	
	EMPLOYEE & CHILDREN	1,446.01	1,396.62	49.39		303-3	
	EMPLOYEE & FAMILY	2,182.20	1,965.32	216.88		303-4	
HEALTH SAVINGS ACCOUNT (HSA) & VISION PLANS Must Pay ALL of Ded 1st, then pays 15%/40% of medical, hospital, emergency room, prescriptions until total out of pocket is met. \$1500 ind/\$3000 fam ded, plus \$4200/\$8400 out of pocket max, 5%/10%/100 ded/30%/50%, \$2000 OOP, Prescription Vision: No co-pay on annual exam, \$150 hardware every 24 months Contribution Limits: Under 55-\$3600 ind/\$7200 fam.			UMP Consumer-Directed Health Plan (CDHP) (HSA) - Premium Includes: Dental, Vision, Basic Life Insurance & EE LTD Coverage - Regence		MARK IF CONTRIB. TO HSA		
			Emp HSA Contribution: \$			306-1	
EMPLOYEE	869.16	970.10	100.94	0.00		301-1	
EMPLOYEE & SPOUSE	1,578.86	1,538.79	0.00	40.07		301-2	
EMPLOYEE & CHILDREN	1,416.02	1,396.62	0.00	19.40		301-3	
EMPLOYEE & FAMILY	2,067.39	1,965.32	0.00	102.07		301-4	
Waiver Fee: If you waive Medical, you must be on Dental, Life & LTD			157.68			302-1	
Tobacco Surcharge: If you, or a dependent covered by the plan, use tobacco products				25.00		302-90	
Spouse or Dom. Partner Coverage Surcharge (go to Spousal Plan Calculator on the web)				50.00		302-91	
C h e c k O n e	1) <input type="checkbox"/> Uniform Dental Plan (Group 3000), OR, Administered by Delta Dental		2) <input type="checkbox"/> WILLAMETTE, (Group 0), OR, 3) <input type="checkbox"/> DELTA CARE GROUP (Group 3100)		MARK ONE PLAN CARRIER AND ONE EMPLOYEE GROUP (X)		
	\$50 deductible in-network, 100% Preventive, \$1750 annual max, 80% basic, 50% major, adult & child orthodontia		IN NETWORK ONLY - Managed Care Plans, Set Rates & No Max Benefit				
	EMPLOYEE			0.00			
	EMPLOYEE & SPOUSE			0.00			
	EMPLOYEE & CHILDREN			0.00			
EMPLOYEE & FAMILY			0.00				
LIFE INSURANCE & AD & D - Administered by Metlife				EMPLOYEE PAYS	MARK ONE (X)		
Life Insurance Amounts: Employee \$35,000 & Additional \$5,000 for accidental death				0.00	X		
LONG TERM DISABILITY (LTD) - Administered by Standard Insurance Co.				0.00	X		
After 90 days being disabled, 60% of 1st \$400 of current earnings. Min \$50 & Max \$240 per month							
VOLUNTARY TAX SAVING PLANS OR ADDITIONAL INSURANCE SELECTION					Monthly Amount		
Flexible Spending Account (FSA), Max \$3,050 - Plus Point			FSA/DCR Fee	\$5.00	92-95	\$	
Dependent Care Reimbursement (DCR) Max \$2,500/\$5,000 - Plus Point			All Self- Paid		\$		
Voluntary Long Term Disability Plan (Income protection if disable)			All Self- Paid			316-1	

Selection Sheet for PEBB Insurance Deductions - Klickitat County

.8 FTE/32 hrs per week - Effective January 1, 2023, premiums reflected on your Dec. 25th payroll check

www.hca.wa.gov/pebb

Print Last Name:					Emp No:		
Signature:					Date:		
<i>I hereby authorize the deductions below and acknowledge that I have been informed of my COBRA rights.</i>							
County contributes 100% for Employee Medical, Dental, Vision, Life Insurance & LTD & 70% of the Additional Cost for Dependent Medical, Dental, Vision, Life Ins & LTD Coverage (County Pays an Avg of 86% for Dep)							
C h e c k (X) O n e P l a n	CLASSIC MEDICAL & VISION PLANS \$250 ind/\$750 fam ded, \$2000 ind/\$4000 fam out of pocket max, 15% office visit co-pay, 15%/40% hospital co-insurance 5%/10%/\$100 ded/30%/50%, \$2000 OOP, Prescription Vision: No co-pay on annual exam, \$150 hardware every 24 months			Uniform Medical Plan (UMP) - Classic Premium <u>Includes:</u> Dental, Vision, Life Insurance & EE LTD Coverage - Administered by Regence		MARK ONE (X)	Ded Code
		PREMIUM	COUNTY PAYS	EMPLOYEE PAYS			
	EMPLOYEE	970.10	776.08	194.02			300-1
	EMPLOYEE & SPOUSE	1,782.52	1,231.03	551.49			300-2
	EMPLOYEE & CHILDREN	1,579.42	1,117.30	462.12			300-3
	EMPLOYEE & FAMILY	2,391.84	1,572.26	819.58			300-4
	SELECT MEDICAL & VISION PLANS \$750 ind/\$2250 fam ded, \$3500 ind/\$7000 fam out of pocket max, 20% office visit co-pay, 15%/40% hospital co-insurance 5%/10%/\$100 ded/30%/50%, \$2000 OOP, Prescription Vision: No co-pay on annual exam, \$150 hardware every 24 months			Uniform Medical Plan (UMP) - Select Premium <u>Includes:</u> Dental, Vision, Life Insurance & EE LTD Coverage - Administered by Regence		MARK ONE (X)	Ded Code
		PREMIUM	COUNTY PAYS	EMPLOYEE PAYS			
	EMPLOYEE	893.87	776.08	117.79			303-1
	EMPLOYEE & SPOUSE	1,630.06	1,231.03	399.03			303-2
	EMPLOYEE & CHILDREN	1,446.01	1,117.30	328.71			303-3
	EMPLOYEE & FAMILY	2,182.20	1,572.26	609.94			303-4
	HEALTH SAVINGS ACCOUNT (HSA) & VISION PLANS Must Pay ALL of Ded 1st, then pays 15%/40% of medical, hospital, emergency room, prescriptions until total out of pocket is met. \$1500 ind/\$3000 fam ded, plus \$4200/\$8400 out of pocket max, 5%/10%/\$100 ded/30%/50%, \$2000 OOP, Prescription Vision: No co-pay on annual exam, \$150 hardware every 24 months Contribution Limits: Under 55-\$3600 ind/\$7200 fam.			UMP Consumer-Directed Health Plan (CDHP) (HSA) - Premium <u>Includes:</u> Dental, Vision, Basic Life Insurance & EE LTD Coverage - Regence		MARK IF CONTRIB. TO HSA	
		Emp HSA Contribution:		\$			306-1
		PREMIUM	COUNTY PAYS	COUNTY PAYS TO HSA 305-1	EMPLOYEE PAYS	MARK ONE (X)	Ded Code
	EMPLOYEE	869.16	776.08	0.00	93.08		301-1
EMPLOYEE & SPOUSE	1,578.86	1,231.03	0.00	347.83		301-2	
EMPLOYEE & CHILDREN	1,416.02	1,117.30	0.00	298.72		301-3	
EMPLOYEE & FAMILY	2,067.39	1,572.26	0.00	495.13		301-4	
Waiver Fee: If you waive Medical, you must be on Dental, Life & LTD		157.68				302-1	
Tobacco Surcharge: If you, or a dependent covered by the plan, use tobacco products				25.00		302-90	
Spouse or Dom. Partner Coverage Surcharge (go to Spousal Plan Calculator on the web)				50.00		302-91	
C h e c k o n e	1) <input type="checkbox"/> Uniform Dental Plan (Group 3000), OR, Administered by Delta Dental		2) <input type="checkbox"/> WILLAMETTE, (Group 0), OR,		MARK ONE PLAN CARRIER AND ONE EMPLOYEE GROUP (X)		
	3) <input type="checkbox"/> DELTA CARE GROUP (Group 3100)		IN NETWORK ONLY - Managed Care Plans, Set Rates & No Max Benefit				
	\$50 deductible in-network, 100% Preventive, \$1750 annual max, 80% basic, 50% major, adult & child orthodontia						
	EMPLOYEE				0.00		
	EMPLOYEE & SPOUSE		0.00				
EMPLOYEE & CHILDREN		0.00					
EMPLOYEE & FAMILY		0.00					
LIFE INSURANCE & AD & D - Administered by Metlife				EMPLOYEE PAYS	MARK ONE (X)		
Life Insurance Amounts: Employee \$35,000 & Additional \$5,000 for accidental death				0.00	X		
LONG TERM DISABILITY (LTD) - Administered by Standard Insurance Co.				0.00	X		
After 90 days being disabled, 60% of 1st \$400 of current earnings. Min \$50 & Max \$240 per month							
VOLUNTARY TAX SAVING PLANS OR ADDITIONAL INSURANCE SELECTION					Monthly Amount	Mark "X"	DC
Flexible Spending Account (FSA), Max \$3,050 - Plus Point			FSA/DCR Fee	\$5.00	92-95	\$	92-5
Dependent Care Reimbursement (DCR) Max \$2,500/\$5,000 - Plus Point			All Self- Paid		\$		92-15
Voluntary Long Term Disability Plan (Income protection if disable)			All Self- Paid				316-1

Selection Sheet for PEBB Insurance Deductions - Klickitat County

.75 FTE/30 hrs per week - Effective January 1, 2023, premiums reflected on your Dec. 25th payroll check

www.hca.wa.gov/pebb

Print Last Name:					Emp No:			
Signature:					Date:			
<i>I hereby authorize the deductions below and acknowledge that I have been informed of my COBRA rights.</i>								
County contributes 100% for Employee Medical, Dental, Vision, Life Insurance & LTD & 70% of the Additional Cost for Dependent Medical, Dental, Vision, Life Ins & LTD Coverage (County Pays an Avg of 86% for Dep)								
C h e c k (X) O n e P l a n	CLASSIC MEDICAL & VISION PLANS			Uniform Medical Plan (UMP) - Classic Premium		MARK ONE (X)	Ded Code	
	\$250 ind/\$750 fam ded, \$2000 ind/\$4000 fam out of pocket max, 15% office visit co-pay, 15%/40% hospital co-insurance 5%/10%/\$100 ded/30%/50%, \$2000 OOP, Prescription Vision: No co-pay on annual exam, \$150 hardware every 24 months			<u>Includes:</u> Dental, Vision, Life Insurance & EE LTD Coverage - Administered by Regence				
				PREMIUM	COUNTY PAYS			EMPLOYEE PAYS
	EMPLOYEE			970.10	727.58			242.52
	EMPLOYEE & SPOUSE			1,782.52	1,154.09			628.43
	EMPLOYEE & CHILDREN			1,579.42	1,047.47	531.95		
	EMPLOYEE & FAMILY			2,391.84	1,473.99	917.85		
	SELECT MEDICAL & VISION PLANS			Uniform Medical Plan (UMP) - Select Premium		MARK ONE (X)	Ded Code	
	\$750 ind/\$2250 fam ded, \$3500 ind/\$7000 fam out of pocket max, 20% office visit co-pay, 15%/40% hospital co-insurance 5%/10%/\$100 ded/30%/50%, \$2000 OOP, Prescription Vision: No co-pay on annual exam, \$150 hardware every 24 months			<u>Includes:</u> Dental, Vision, Life Insurance & EE LTD Coverage - Administered by Regence				
				PREMIUM	COUNTY PAYS			EMPLOYEE PAYS
	EMPLOYEE			893.87	727.58			166.29
	EMPLOYEE & SPOUSE			1,630.06	1,154.09			475.97
	EMPLOYEE & CHILDREN			1,446.01	1,047.47	398.54		
	EMPLOYEE & FAMILY			2,182.20	1,473.99	708.21		
	HEALTH SAVINGS ACCOUNT (HSA) & VISION PLANS			UMP Consumer-Directed Health Plan (CDHP)		MARK IF CONTRIB. TO HSA		
	Must Pay ALL of Ded 1st, then pays 15%/40% of medical, hospital, emergency room, prescriptions until total out of pocket is met. \$1500 ind/\$3000 fam ded, plus \$4200/\$8400 out of pocket max, 5%/10%/\$100 ded/30%/50%, \$2000 OOP, Prescription Vision: No co-pay on annual exam, \$150 hardware every 24 months Contribution Limits: Under 55-\$3600 ind/\$7200 fam.			(HSA) - Premium <u>Includes:</u> Dental, Vision, Basic Life Insurance & EE LTD Coverage - Regence				
			Emp HSA Contribution: \$			306-1		
			PREMIUM	COUNTY PAYS	COUNTY PAYS TO HSA 305-1	EMPLOYEE PAYS		
EMPLOYEE			869.16	727.58	0.00	141.58		
EMPLOYEE & SPOUSE			1,578.86	1,154.09	0.00	424.77		
EMPLOYEE & CHILDREN			1,416.02	1,047.47	0.00	368.55		
EMPLOYEE & FAMILY			2,067.36	1,473.99	0.00	593.37		
Waiver Fee: If you waive Medical, you must be on Dental, Life & LTD				157.68		302-1		
Tobacco Surcharge: If you, or a dependent covered by the plan, use tobacco products					25.00	302-90		
Spouse or Dom. Partner Coverage Surcharge (go to Spousal Plan Calculator on the web)					50.00	302-91		
C h e c k O n e	1) <input type="checkbox"/> Uniform Dental Plan (Group 3000), OR, Administered by Delta Dental		2) <input type="checkbox"/> WILLAMETTE, (Group 0), OR,		MARK ONE PLAN CARRIER AND ONE EMPLOYEE GROUP (X)			
	3) <input type="checkbox"/> DELTA CARE GROUP (Group 3100)							
	\$50 deductible in-network, 100% Preventive, \$1750 annual max, 80% basic, 50% major, adult & child orthodontia		IN NETWORK ONLY - Managed Care Plans, Set Rates & No Max Benefit					
	EMPLOYEE		0.00					
	EMPLOYEE & SPOUSE		0.00					
EMPLOYEE & CHILDREN		0.00						
EMPLOYEE & FAMILY		0.00						
LIFE INSURANCE & AD & D - Administered by Metlife					EMPLOYEE PAYS	MARK ONE (X)		
Life Insurance Amounts: Employee \$35,000 & Additional \$5,000 for accidental death					0.00	X		
LONG TERM DISABILITY (LTD) - Administered by Standard Insurance Co.					0.00	X		
After 90 days being disabled, 60% of 1st \$400 of current earnings. Min \$50 & Max \$240 per month								
VOLUNTARY TAX SAVING PLANS OR ADDITIONAL INSURANCE SELECTION					Monthly Amount		Mark "X"	DC
Flexible Spending Account (FSA), Max \$3,050 - Plus Point			FSA/DCR Fee	\$5.00	92-95	\$	92-5	
Dependent Care Reimbursement (DCR) Max \$2,500/\$5,000 - Plus Point			All Self- Paid		\$		92-15	
Voluntary Long Term Disability Plan (Income protection if disable)			All Self- Paid				316-1	

Selection Sheet for PEBB Insurance Deductions - Klickitat County

.7 FTE/28 hrs per week - Effective January 1, 2023, premiums reflected on your Dec. 25th payroll check

www.hca.wa.gov/pebb

Print Last Name:					Emp No:		
Signature:					Date:		
<i>I hereby authorize the deductions below and acknowledge that I have been informed of my COBRA rights.</i>							
County contributes 100% for Employee Medical, Dental, Vision, Life Insurance & LTD & 70% of the Additional Cost for Dependent Medical, Dental, Vision, Life Ins & LTD Coverage (County Pays an Avg of 86% for Dep)							
C h e c k (X) O n e P l a n	CLASSIC MEDICAL & VISION PLANS \$250 ind/\$750 fam ded, \$2000 ind/\$4000 fam out of pocket max, 15% office visit co-pay, 15%/40% hospital co-insurance 5%/10%/\$100 ded/30%/50%, \$2000 OOP, Prescription Vision: No co-pay on annual exam, \$150 hardware every 24 months			Uniform Medical Plan (UMP) - Classic Premium <u>Includes:</u> Dental, Vision, Life Insurance & EE LTD Coverage - Administered by Regence		MARK ONE (X)	Ded Code
	EMPLOYEE	970.10	679.07	291.03		300-1	
	EMPLOYEE & SPOUSE	1,782.52	1,077.15	705.37		300-2	
	EMPLOYEE & CHILDREN	1,579.42	977.63	601.79		300-3	
	EMPLOYEE & FAMILY	2,391.84	1,375.72	1,016.12		300-4	
	SELECT MEDICAL & VISION PLANS \$750 ind/\$2250 fam ded, \$3500 ind/\$7000 fam out of pocket max, 20% office visit co-pay, 15%/40% hospital co-insurance 5%/10%/\$100 ded/30%/50%, \$2000 OOP, Prescription Vision: No co-pay on annual exam, \$150 hardware every 24 months			Uniform Medical Plan (UMP) - Select Premium <u>Includes:</u> Dental, Vision, Life Insurance & EE LTD Coverage - Administered by Regence		MARK ONE (X)	Ded Code
	EMPLOYEE	893.87	679.07	214.80		303-1	
	EMPLOYEE & SPOUSE	1,630.06	1,077.15	552.91		303-2	
	EMPLOYEE & CHILDREN	1,446.01	977.63	468.38		303-3	
	EMPLOYEE & FAMILY	2,182.20	1,375.72	806.48		303-4	
	HEALTH SAVINGS ACCOUNT (HSA) & VISION PLANS Must Pay ALL of Ded 1st, then pays 15%/40% of medical, hospital, emergency room, prescriptions until total out of pocket is met. \$1500 ind/\$3000 fam ded, plus \$4200/\$8400 out of pocket max, 5%/10%/\$100 ded/30%/50%, \$2000 OOP, Prescription Vision: No co-pay on annual exam, \$150 hardware every 24 months Contribution Limits: Under 55-\$3600 ind/\$7200 fam.			UMP Consumer-Directed Health Plan (CDHP) (HSA) - Premium <u>Includes:</u> Dental, Vision, Basic Life Insurance & EE LTD Coverage - Regence		MARK IF CONTRIB. TO HSA	
				Emp HSA Contribution: \$			306-1
		PREMIUM	COUNTY PAYS	COUNTY PAYS TO HSA 305-1	EMPLOYEE PAYS	MARK ONE (X)	Ded Code
	EMPLOYEE	869.16	679.07	0.00	190.09		301-1
	EMPLOYEE & SPOUSE	1,578.86	1,077.15	0.00	501.71		301-2
	EMPLOYEE & CHILDREN	1,416.02	977.63	0.00	438.39		301-3
EMPLOYEE & FAMILY	2,067.39	1,375.72	0.00	691.67		301-4	
Waiver Fee: If you waive Medical, you must be on Dental, Life & LTD		157.68				302-1	
Tobacco Surcharge: If you, or a dependent covered by the plan, use tobacco products				25.00		302-90	
Spouse or Dom. Partner Coverage Surcharge (go to Spousal Plan Calculator on the web)				50.00		302-91	
C h e c k o n e	1) <input type="checkbox"/> Uniform Dental Plan (Group 3000), OR, Administered by Delta Dental		2) <input type="checkbox"/> WILLAMETTE, (Group 0), OR,		MARK ONE PLAN CARRIER AND ONE EMPLOYEE GROUP (X)		
	3) <input type="checkbox"/> DELTA CARE GROUP (Group 3100)						
	\$50 deductible in-network, 100% Preventive, \$1750 annual max, 80% basic, 50% major, adult & child orthodontia		IN NETWORK ONLY - Managed Care Plans, Set Rates & No Max Benefit				
	EMPLOYEE			0.00			
	EMPLOYEE & SPOUSE			0.00			
EMPLOYEE & CHILDREN			0.00				
EMPLOYEE & FAMILY			0.00				
LIFE INSURANCE & AD & D - Administered by Metlife				EMPLOYEE PAYS	MARK ONE (X)		
Life Insurance Amounts: Employee \$35,000 & Additional \$5,000 for accidental death				0.00	X		
LONG TERM DISABILITY (LTD) - Administered by Standard Insurance Co.				0.00	X		
After 90 days being disabled, 60% of 1st \$400 of current earnings. Min \$50 & Max \$240 per month							
VOLUNTARY TAX SAVING PLANS OR ADDITIONAL INSURANCE SELECTION					Monthly Amount	Mark "X"	DC
Flexible Spending Account (FSA), Max \$3,050 - Plus Point			FSA/DCR Fee	\$5.00	92-95	\$	92-5
Dependent Care Reimbursement (DCR) Max \$2,500/\$5,000 - Plus Point			All Self- Paid		\$		92-15
Voluntary Long Term Disability Plan (Income protection if disable)			All Self- Paid				316-1

Selection Sheet for PEBB Insurance Deductions - Klickitat County

.6 FTE/24 hr per week - Effective January 1, 2023, premiums reflected on your Dec. 25th payroll check

www.hca.wa.gov/pebb

Print Last Name:					Emp No:		
Signature:					Date:		
<i>I hereby authorize the deductions below and acknowledge that I have been informed of my COBRA rights.</i>							
County contributes 100% for Employee Medical, Dental, Vision, Life Insurance & LTD & 70% of the Additional Cost for Dependent Medical, Dental, Vision, Life Ins & LTD Coverage (County Pays an Avg of 86% for Dep)							
C h e c k (X) O n e P l a n	CLASSIC MEDICAL & VISION PLANS \$250 ind/\$750 fam ded, \$2000 ind/\$4000 fam out of pocket max, 15% office visit co-pay, 15%/40% hospital co-insurance 5%/10%/\$100 ded/30%/50%, \$2000 OOP, Prescription Vision: No co-pay on annual exam, \$150 hardware every 24 months			Uniform Medical Plan (UMP) - Classic Premium <u>Includes:</u> Dental, Vision, Life Insurance & EE LTD Coverage - Administered by Regence		MARK ONE (X)	Ded Code
		PREMIUM	COUNTY PAYS	EMPLOYEE PAYS			
	EMPLOYEE	970.10	582.06	388.04		300-1	
	EMPLOYEE & SPOUSE	1,782.52	923.27	859.25		300-2	
	EMPLOYEE & CHILDREN	1,579.42	837.97	741.45		300-3	
	EMPLOYEE & FAMILY	2,391.84	1,179.19	1,212.65		300-4	
	SELECT MEDICAL & VISION PLANS \$750 ind/\$2250 fam ded, \$3500 ind/\$7000 fam out of pocket max, 20% office visit co-pay, 15%/40% hospital co-insurance 5%/10%/\$100 ded/30%/50%, \$2000 OOP, Prescription Vision: No co-pay on annual exam, \$150 hardware every 24 months			Uniform Medical Plan (UMP) - Select Premium <u>Includes:</u> Dental, Vision, Life Insurance & EE LTD Coverage - Administered by Regence		MARK ONE (X)	Ded Code
		PREMIUM	COUNTY PAYS	EMPLOYEE PAYS			
	EMPLOYEE	893.87	582.06	311.81		303-1	
	EMPLOYEE & SPOUSE	1,630.06	923.27	706.79		303-2	
	EMPLOYEE & CHILDREN	1,446.01	837.97	608.04		303-3	
	EMPLOYEE & FAMILY	2,182.20	1,179.19	1,003.01		303-4	
	HEALTH SAVINGS ACCOUNT (HSA) & VISION PLANS Must Pay ALL of Ded 1st, then pays 15%/40% of medical, hospital, emergency room, prescriptions until total out of pocket is met. \$1500 ind/\$3000 fam ded, plus \$4200/\$8400 out of pocket max, 5%/10%/\$100 ded/30%/50%, \$2000 OOP, Prescription Vision: No co-pay on annual exam, \$150 hardware every 24 months Contribution Limits: Under 55-\$3600 ind/\$7200 fam.			UMP Consumer-Directed Health Plan (CDHP) (HSA) - Premium <u>Includes:</u> Dental, Vision, Basic Life Insurance & EE LTD Coverage - Regence		MARK IF CONTRIB. TO HSA	
				Emp HSA Contribution: \$			306-1
		PREMIUM	COUNTY PAYS	COUNTY PAYS TO HSA 305-1	EMPLOYEE PAYS	MARK ONE (X)	Ded Code
	EMPLOYEE	869.16	582.06	0.00	287.10		301-1
EMPLOYEE & SPOUSE	1,578.86	923.27	0.00	655.59		301-2	
EMPLOYEE & CHILDREN	1,416.02	837.97	0.00	578.05		301-3	
EMPLOYEE & FAMILY	2,067.39	1,179.19	0.00	888.20		301-4	
Waiver Fee: If you waive Medical, you must be on Dental, Life & LTD		157.68				302-1	
Tobacco Surcharge: If you, or a dependent covered by the plan, use tobacco products				25.00		302-90	
Spouse or Dom. Partner Coverage Surcharge (go to Spousal Plan Calculator on the web)				50.00		302-91	
C h e c k o n e	1) <input type="checkbox"/> Uniform Dental Plan (Group 3000), OR, Administered by Delta Dental		2) <input type="checkbox"/> WILLAMETTE, (Group 0), OR,		MARK ONE PLAN CARRIER AND ONE EMPLOYEE GROUP (X)		
	3) <input type="checkbox"/> DELTA CARE GROUP (Group 3100)		IN NETWORK ONLY - Managed Care Plans, Set Rates & No Max Benefit				
	\$50 deductible in-network, 100% Preventive, \$1750 annual max, 80% basic, 50% major, adult & child orthodontia						
	EMPLOYEE				0.00		
	EMPLOYEE & SPOUSE		0.00				
EMPLOYEE & CHILDREN		0.00					
EMPLOYEE & FAMILY		0.00					
LIFE INSURANCE & AD & D - Administered by Metlife			EMPLOYEE PAYS	MARK ONE (X)			
Life Insurance Amounts: Employee \$35,000 & Additional \$5,000 for accidental death			0.00	X			
LONG TERM DISABILITY (LTD) - Administered by Standard Insurance Co.			0.00	X			
After 90 days being disabled, 60% of 1st \$400 of current earnings. Min \$50 & Max \$240 per month							
VOLUNTARY TAX SAVING PLANS OR ADDITIONAL INSURANCE SELECTION				Monthly Amount		Mark "X"	DC
Flexible Spending Account (FSA), Max \$3,050 - Plus Point		FSA/DCR Fee	\$5.00	92-95	\$		92-5
Dependent Care Reimbursement (DCR) Max \$2,500/\$5,000 - Plus Point		All Self- Paid		\$			92-15
Voluntary Long Term Disability Plan (Income protection if disable)		All Self- Paid					316-1