



Employee Insurance Benefit Information

Insurance benefits are available for eligible employees only, which includes full-time status and an evaluation period after hire. This document is for reference only. An enrollment form needs to be completed in order to enroll in any plans. For additional details including plan specific information, any questions, or to enroll in a plan, contact HR Manager Katie Apezteguia at office@familyreliefresources.com or 503-344-7731.

Kaiser Permanente Medical Plan options:

Family Relief Resources contributes up to \$550 for the monthly plan cost. All plan options include naturopathic, chiropractor and acupuncture benefits.

The numbers at the end of each plan title mean the following:

Deductible/PCP Office Visit copay/Coinsurance/Out-of-pocket (OOP) maximum

Plan name	Employee only cost	Employee and spouse	Employee and child(ren)	Employee and family
CSH4-DED PLAN B 500/10/20%/2000	\$766.39 (\$216.39 after FRR contribution)	\$1,532.78 (\$982.78 after FRR contribution)	\$1,379.50 (\$829.50 after FRR contribution)	\$2,299.17 (\$1,749.17 after FRR contribution)
DUM4-DUAL CHOICE PPO PLAN B* 500/10/20%/3000	\$908.89 (\$358.89 after FRR contribution)	\$1,817.78 (\$1,267.78 after FRR contribution)	\$1,636.00 (\$1,086.00 after FRR contribution)	\$2,726.67 (\$2,176.67 after FRR contribution)
BSL4-DED PLAN L 6000/35/20%/7500	\$551.22 (\$0 after FRR contribution)	\$1,102.44 (\$552.44 after FRR contribution)	\$992.20 (\$442.20 after FRR contribution)	\$1,653.66 (\$1,103.66 after FRR contribution)

* The dual choice PPO plan also includes access to some providers outside of the Kaiser Network.



United Healthcare Dental Plan Options:

Dental and vision are fully paid by the employee.

Plan name	Subscriber only cost	Subscriber and spouse	Subscriber and Child(ren)	Subscriber and family
Dental	\$49.25	\$98.48	\$109.46	\$166.74

	Benefit	In/Out
Plan Maximums	Annual In/Out of Network	\$1,500 / \$1,500
	Ortho Lifetime	NA / NA
Deductible	Individual/Family	\$50 / \$150
Waiting Period	Major Services	NO WAIT
Coinsurance	Preventive	100% / 100%
	Minor Restore	80% / 80%
	Endo/Perio/Oral*	80% / 80%
	Major Services	50% / 50%
	Orthodontia	NA / NA

Dental plan overview

Contact HR for additional plan details, questions, or enrollment.



United Healthcare Vision Plan Options

Plan name	Subscriber only cost	Subscriber and spouse	Subscriber and Child(ren)	Subscriber and family
Vision	\$5.94	\$11.26	\$13.21	\$18.60

	Services & Materials	Amount
In-Network Copay	Exam	\$10
	Materials	\$25
Allowances	Frame	\$130
	Elective Contact Lens	\$105
Frequencies	Exam	1 x per 12 mos
	Lenses	1 x per 12 mos
	Frame	1 x per 12 mos
Out-of-Network Reimbursement	Exam	Up to \$40
	Eyeglass Lenses	Up to \$80
	Frame	Up to \$45

Vision plan overview

Contact HR for additional plan details, questions, or enrollment.