Marion County Law Enforcement Association (MCLEA)

2022 MARION COUNTY HEALTH PLAN COMPARISON

Please Note: This is a summary of benefits only. For a complete description of benefits refer to the carrier's benefit summary located on the Marion County website at **http://www.co.marion.or.us/HR/Benefits/Pages/cobraretiree.aspx** or contact your carrier: PacificSource at 1-888-977-9299 or Kaiser Permanente at 800-813-2000. Claims will be paid per the carrier's information and contract.

MEDICAL SERVICES	**PacificSource PPO Plan Preferred Provider Organization Plan**	**Kaiser HMO Plan Health Management Organization**
Annual Deductible	$100 per person / $300 family max	None
Annual Out-of-pocket Maximum	In-Network: $800 per person/ $4,000 per family Out-of-Network: $1,600 per person/ Unlimited	$600 per member $1200 per family
Essential Benefit Maximum	Unlimited	Unlimited
MEDICAL SERVICES	**After Deductible is met EMPLOYEE PAYS (Deductible waived for services with *)**	**EMPLOYEE PAYS**
Office Visits (including Mental Health, Specialist and Naturopath Visits)	20% In-Network / 40% Out-of-Network	$5
Preventive Care: Well baby/Well child visits Preventive physicals Well woman visits & preventive mammograms Preventive colonoscopy & Prostate cancer screening Immunizations	No charge if In-Network* 40% Out-of-Network No charge for childhood immunizations from out-of-network providers	No charge if using Kaiser facility
Routine Diagnostic Lab & X-Ray	20% In-Network*/ 40% Out-of-Network	$0
High Cost Imaging (CT/PET/MRI/scans)	20% In-Network / 40% Out-of-Network	$0
Outpatient Surgery	In Network: Hospital: 30% Surgery Center: 20% Out of Network: Hospital: 50% Surgery Center: 40%	$5
Hospital Semi-Private Room & Board and Inpatient Surgery	$100 co-pay per admit, plus: 20% In-Network / 40% Out-of-Network	$0
Maternity Care Delivery covered as hospitalization services above	20% In-Network / 40% Out-of-Network	Office Visits: $0 Hospital**:** $0
Emergency Room Facility & Urgent Care Visits	ER: $100 co-pay then 20%* Urgent Care: 20%*	ER**:** $5 (Waived if admitted) Urgent Care: $10
Ambulance (Emergency Transport)	20%	$0
Alternative Care	$1,000 Annual Max 20%***** per visit	$5 (physician-referred)
Mental Health/Chemical Dependency Some services may also be available outside of your medical benefits. If interested, contact Cascade EAP for details 503-588-0777.	**Inpatient Treatment**: In-Network: $100 co-pay per admit, plus 20%* Out-of-Network: $100 co-pay per admit, 40% co-insurance **Outpatient Treatment**: 20% In-Network / 40% Out-of-Network	Inpatient Hospital & Residential Services: $0 Outpatient Services: $5 per visit
Durable Medical Equipment	20% In-Network / 40% Out-of-Network	20% co-insurance
Prescriptions	In Network Pharmacy: Drugs on Preventive & Incentive Drug List: $0, deductible waived[1] See list: https://pacificsource.com/drug-list/ Tier 1^, 2 and 3 Drugs: After deductible, 20%	$10 generic/$20 brand. Mail delivery: 90-day supply of maintenance drugs for two

*Deductible Waived After meeting your deductible you are responsible for the coinsurance.

PacificSource: The deductible, co-payments, and coinsurance accrue toward the in-network out-of-pocket maximum. Kaiser HMO: All deductible, copayment and coinsurance amounts count toward the maximum out-ofpocket, except Alternative Care, Hearing Aids and Vision Hardware.

^Tier 1 prescriptions with PacificSource are typically generics.

VISION SERVICES	PacificSource PPO Plan	Kaiser HMO Plan
The carrier you choose for medical services will be your vision carrier as well	Please visit this website to locate approved providers: https://pacificsource.com/find-a-provider/	**MUST USE KAISER FACILITIES**
Routine Eye Exam	1 exam every 12 months with PacificSource Network Provider	$5
Lenses, Frames & Contact Lenses	$200 frame/contact lens allowance every 24 months with PacificSource Network Provider Lenses based on fee schedule.	Maximum Plan Allowance: **Adults**: $150 allowance every 2 calendar years toward lenses, frames or contacts. **Ages 18 & Younger:** No charge for one pair standard frames and lenses or 12-month supply contact lenses every 12 months.

DENTAL SERVICES	DELTA DENTAL PLAN Group # 10001745-class 1	KAISER DENTAL PLAN Group #17372-AA-004
Deductible	None	None
Annual Maximum Paid By Plan	$1,500	None
Preventive (Class I)	**EMPLOYEE PAYS**	**EMPLOYEE PAYS**
Examination & X-rays; Sealants & Prophylaxis (cleanings)	No charge, when seeking services from a Delta participating provider. Diagnostic & x-ray services every 5 years Bite-wing x-rays once a year.	No charge Cleanings: 2 visits in any 12 consecutive month period
Basic (Class II)	**EMPLOYEE PAYS**	**EMPLOYEE PAYS**
Limitations may apply, contact carrier **Restorative Dentistry, Simple Extractions, Endodontics (pulpal therapy & root canal filling)**	No charge when seeking services from a Delta participating provider. (For posterior composite fillings, you pay cost difference of amalgam and composite.)	No charge
Major (Class III)	**EMPLOYEE PAYS**	**EMPLOYEE PAYS**
Limitations may apply, contact carrier **Cast Restorations, Crowns** **Oral Surgery** **Periodontics (treatment of tissues supporting the teeth)** **Bridges, Dentures & Partials**	50% coinsurance	Crown (Plastic/Acrylic/Steel) $0 Crown (Gold/Porcelain) $45 Oral Surgery & Periodontics $0 Bridge Abutments $45 Dentures $95 each partial;$65 full; $25 reline
Orthodontia	**EMPLOYEE PAYS**	**EMPLOYEE PAYS**
	20% (up to $700 lifetime maximum benefit per eligible member) then employee pays 100%	Not Covered

Important Notice: The Women's Health & Cancer Rights Act of 1998 requires all plans to provide benefits for all mastectomy-related services including reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy (including lymphedemas). Call your carrier's customer service line for details.

MONTHLY PREMIUM COSTS: Effective January 1, 2022 through December 31, 2022 .

Medical & Dental Plans	Subscriber Only	Subscriber + 1	Subscriber + 2	COBRA (ALL FAMILY MEMBERS)
Kaiser HMO Medical	$686.54	$1,373.08	$2,059.62	$1,563.37
Pacific Source PPO Medical	$919.68	$1,699.18	$2,570.91	$2,067.13
Kaiser HMO Dental	$72.19	$144.38	$216.57	$164.65
Delta Dental	$ 65.42	$ 119.69	$180.51	$145.16

Revised **10/12/2021**