2022 MARION COUNTY HEALTH PLANS SUMMARY

For MCEA, MCJEA, FOPPO, ONA, Represented Employees, Unit 12, Unit 13, and Management. 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/bs/benefits/Pages/default.aspx or contact the carrier:
Kaiser Permanente at 800-813-2000 or PacificSource at 888- 977-9299. Claims will be paid according to the carrier contact.

MEDICAL SERVICES	PacificSource HDHP* PPO** with HSA***		PacificSource Health Traditional PPO**		Kaiser HMO****
	In-Network	Out-of-Network	In-Network	Out-of-Network	Kaiser Facilities Only
County Annual HSA Employer Contribution	$650 Employee Only / $1,300 Family *Amount pro-rated based on the medical plan effective date.*		N/A		N/A
Annual Deductible Deductible must be met before benefits are paid	$1,400 Employee Only / $2,800 Family *Family deductible is combined and can be met by 1 family member*		$300 per Person $900 per Family		$500 per Person $1,500 per Family Deductible applies to services in yellow below
Annual Out-of-Pocket Maximum	$3,000 Single $6,000 Family	$7,600 Single $15,200 Family	$5,000 Single $10,000 Family	$10,000 Single $20,000 Family	$3,000 Single $9,000 Family
Essential Benefit Max	Unlimited		Unlimited		Unlimited
	After Deductible Member Pays		**After Deductible Member Pays**		**After Deductible Member Pays**
Preventive Services Well Baby Visits to age 2 Standard Immunizations Annual Exams	Paid in Full	40%	Paid in Full	50%	Paid in Full
Office Visits (includes Mental Health and Naturopath)	20%	40%	$15 co-pay[1] for visit **other services 30%**	50%	$15 co-pay[1]
Specialist Visits	20%	40%		50%	$30 co-pay[1]
Urgent Care Visits	20%	40%		50%	$40 co-pay[1]
Lab & X-Ray	20%	40%	30%[1]	50%	$15 co-pay per department visit[1]
MRI/CAT/PET	20%	40%	$100 copay, then deducible and 30%	$100 copay, then deductible and 50%	$100[1] per department visit
Emergency Room Facility	20%		$200 co-pay[1], then 30% Co-pay waived if admitted		$200 after Deductible (Waived if admitted)
Ambulance	20%		30**%**		20% Coinsurance after Deductible
Hospital Semi-Private Room & Board	20%	40%	$100 co-pay then 30%	$100 co-pay then 50%	$100 per day[1] up to $500 per admission
Surgery	20%	40%	30%	50%	Included in Hospital Benefit
Physical/Speech/Chemo/ Occupational Therapy	20%	40%	30%	50%	$30 (up to 20 visits per therapy per Calendar Year)
Durable Medical Equip.	20%	40%	30%	50%	20% Coinsurance after Deductible
Outpatient Surgery	Hospital:20% Surgery Center: 10%	Hospital:50% Surgery Center:40%	Hospital:30% Surgery Center:20%	Hospital:50% Surgery Center: 40%	$20
Maternity Care Delivery covered as hospitalization.	20%	40%	30%	50%	$0 for scheduled prenatal care and first postpartum visit
Skilled Nursing Facility Care	20%	40%	$100 copay, then deducible and 30%	$100 copay, then deductible and 50%	$0 up to 100 days per Calendar Year
Prescriptions (Rx)	In Network Pharmacy: Drugs on Preventive & Incentive Drug List: $0, deductible waived[1] Tier 1^, 2 and 3 Drugs: After deductible, 20% List: https://pacificsource.com/drug-list/		In Network Pharmacy: Drugs on Preventive & Incentive Drug List: $0, deductible waived. Tier 1^ - $10, Tier 2[1] - $30, Tier 3[1] – 50% List: https://pacificsource.com/drug-list/		Generic: $10[1] Preferred Brand: $30[1] Formulary Contraceptives: $0 Non-Preferred Brand/Specialty: 50% up to $100 Max. Mail order 90-day supply: for two copayments; maintenance medications only.
Alternative Care Chiropractic & Acupuncture	$1,500 combined annual max.		$1,500 combined annual max[1]		$40[1] Chiropractic care up to 20 visits/year $40[1] Acupuncture care up to 12 visits/year $25[1] Massage therapy up to 12 visits/year
	20%	40%	30%		

[1] **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-of-pocket, except Alternative Care, Hearing Aids and Vision Hardware. ^**Tier 1 prescriptions** with PacificSource are typically generics.

VISION SERVICES The carrier you choose for medical services will be your vision carrier as well.	**PacificSource HDHP* PPO** with HSA**** Please visit this website to locate approved providers: **https://pacificsource.com/find-a-provider/**	***PacificSource Health Traditional PPO**** Please visit this website to locate approved providers: **https://pacificsource.com/find-a-provider/**	**Kaiser HMO***** **MUST USE KAISER FACILITIES ONLY**
Routine Eye Exam	$10.00 co-pay 1 Exam every 12 months with in-network provider[1]	$10.00 co-pay 1 Exam every 12 months in-network provider[1]	$10.00 co-pay 1 Exam every 12 months in-network provider[1]
Lenses, Frames & Contact Lenses	$200 Frame/Contact Lens allowance every 12 months w/ in-network provider. Lenses covered in full (excludes coatings)	$200 Frame/Contact Lens allowance every 12 months w/ in-network provider. Lenses covered in full (excludes coatings)	$200 Frame/Contact Lens allowance every 12 months w/ in-network provider. Lenses covered in full (excludes coatings)

DENTAL SERVICES	**Delta Dental Plan (Formerly Moda)**	**Kaiser Dental Plan MUST USE KAISER FACILITIES ONLY**
Deductible	$50 per Member / $150 per Family	$25 per Member / $75 per Family
Annual Maximum	Up to $2,000 per Member paid by Delta, preventive services will not be counted towards annual maximum	Up to $2,000 per Member per Calendar Year paid by KP
Preventive	**Member Pays**	**Member Pays**
Routine Exam & X-Rays Prophylaxis (cleanings) Sealants & Fluoride Space Maintainers	0% (deductible waived), when seeking services from an Delta participating provider Diagnostic and x-ray services every 5 years Bite-wing x-rays once a year	$0% (deductible waived), when seeking services from a KP facility Exams: 2 in any 12 consecutive month period
Basic	**After Deductible Member Pays**	**After Deductible Member Pays**
Endodontics (pulpal therapy & root canal filling) Restorative Fillings	20% coinsurance	$0 for Restorative Fillings 20% for Endodontics
Major	**After Deductible Member Pays**	**After Deductible Member Pays**
Crowns Cast Restorations Prosthetics (Dentures & Bridge Work)	50% (Includes Oral Surgery & Periodontics)	50% coinsurance for all except $0% Oral Surgery 20% Periodontics
Orthodontia	50% up to $1,000 lifetime maximum benefit per eligible member, then member pays the balance	50% up to $1,000 lifetime maximum benefit per eligible member, then member pays the balance

2022 MONTHLY PREMIUM COSTS

Premiums include coverage for eligible family members. County premium cap is $1,596 for all except MCJEA (Juvenile Employees Association with a cap of $1646 and FOPPO (Parole & Probation Deputies) with a cap of $1,850.

Choice of Medical & Dental Plans (monthly premium amounts)	**Combined Monthly Premium**	**Marion County's Monthly Cost**	**Employee's Monthly Cost**			**Employee's Twice-Monthly Deduction**		
			MCJEA	**FOPPO**	**Other**	**MCJEA**	**FOPPO**	**Other**
Kaiser HMO & Kaiser Dental	**$1,726.43**	**$1,596.00**	**$80.44**	**$0**	**$130.44**	**$40.22**	**$0**	**$65.22**
Kaiser HMO & Delta Dental	**$1,727.73**	**$1,596.00**	**$81.74**	**$0**	**$131.74**	**$40.87**	**$0**	**$65.87**
PacificSource PPO & Kaiser Dental	**$1,768.32**	**$1,596.00**	**$122.32**	**$0**	**$172.32**	**$61.16**	**$0**	**$86.16**
PacificSource PPO & Delta Dental	**$,1769.62**	**$1,596.00**	**$123.62**	**$0**	**$173.62**	**$61.81**	**$0**	**$86.81**
PacificSource HDHP & Kaiser Dental	**$1,568.04**	**$1,596.00**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
PacificSource HDHP & Delta Dental	**$1,569.34**	**$1,596.00**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**

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.

* HDHP = High Deductible Health Plan
**HSA = Health Savings Arrangement
***PPO = Preferred Provider Organization (network)
****HMO = Health Management Organization