

# 2023 MARION COUNTY HEALTH PLANS SUMMARY

For all benefited employees except those represented by MCLEA. 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 [www.co.marion.or.us/hr/benefits/Pages/default.aspx](http://www.co.marion.or.us/hr/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
	\$650 Employee Only / \$1,300 Family <i>Amount pro-rated based on the medical plan effective date.</i>		N/A		N/A
County Annual HSA Employer Contribution					
Annual Deductible Deductible must be met before benefits are paid	\$1,500 Employee Only / \$3,000 Family <i>Family deductible is combined and can be met by 1 family member</i>		\$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 <sup>1</sup> for visit other services 30%	50%	\$15 co-pay <sup>1</sup>
Specialist Visits	20%	40%		50%	\$30 co-pay <sup>1</sup>
Urgent Care Visits	20%	40%		50%	\$40 co-pay <sup>1</sup>
Lab & X-Ray	20%	40%	30% <sup>1</sup>	50%	\$15 co-pay per department visit <sup>1</sup>
MRI/CAT/PET	20%	40%	\$100 copay, then deductible and 30%	\$100 copay, then deductible and 50%	\$100 <sup>1</sup> per department visit
Emergency Room Facility	20%		\$200 co-pay <sup>1</sup> , 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 <sup>1</sup> 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 deductible 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 <sup>1</sup> Tier 1 <sup>^</sup> , 2 and 3 Drugs: After deductible, 20% List: <a href="https://pacificsource.com/drug-list/">https://pacificsource.com/drug-list/</a>		In Network Pharmacy: Drugs on Preventive & Incentive Drug List: \$0, deductible waived. Tier 1 <sup>^</sup> - \$10, Tier 2 <sup>1</sup> - \$30, Tier 3 <sup>1</sup> – 50% List: <a href="https://pacificsource.com/drug-list/">https://pacificsource.com/drug-list/</a>		Generic: \$10 <sup>1</sup> Preferred Brand: \$30 <sup>1</sup> 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 <sup>1</sup>		\$40 <sup>1</sup> Chiropractic care up to 20 visits/year \$40 <sup>1</sup> Acupuncture care up to 12 visits/year \$25 <sup>1</sup> Massage therapy up to 12 visits/year
	20%	40%	30%		

<sup>1</sup> **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. <sup>^</sup>**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**	*PacificSource Health Traditional PPO**	Kaiser HMO****
	Please visit this website to locate approved providers: <a href="https://pacificsource.com/find-a-provider/">https://pacificsource.com/find-a-provider/</a>	Please visit this website to locate approved providers: <a href="https://pacificsource.com/find-a-provider/">https://pacificsource.com/find-a-provider/</a>	MUST USE KAISER FACILITIES ONLY
	\$10.00 co-pay 1 Exam every 12 months with in-network provider <sup>1</sup>	\$10.00 co-pay 1 Exam every 12 months in-network provider <sup>1</sup>	\$10.00 co-pay 1 Exam every 12 months in-network provider <sup>1</sup>
Routine Eye Exam			
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.

DEDENTAL 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

## 2023 MONTHLY PREMIUM COSTS

Premiums include coverage for eligible family members. County premium cap is \$1,621 for all except MCJEA (Juvenile Employees Association) with a cap of \$1,671 and FOPPO (Parole & Probation Deputies) with a cap of \$2,040.

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	\$1,647.42	\$1,621.00	\$0	\$0	\$26.42	\$0	\$0	\$13.21
Kaiser HMO & Delta Dental	\$1,648.72	\$1,621.00	\$0	\$0	\$27.72	\$0	\$0	\$13.86
PacificSource PPO & Kaiser Dental	\$1,883.18	\$1,621.00	\$212.18	\$0	\$262.18	\$106.09	\$0	\$131.09
PacificSource PPO & Delta Dental	\$1,884.48	\$1,621.00	\$213.48	\$0	\$263.48	\$106.74	\$0	\$131.74
PacificSource HDHP & Kaiser Dental	\$1,654.48	\$1,621.00	\$0	\$0	\$33.48	\$0	\$0	\$16.74
PacificSource HDHP & Delta Dental	\$1,655.78	\$1,621.00	\$0	\$0	\$34.78	\$0	\$0	\$17.39

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