

2027 MARION COUNTY RETIREE & COBRA HEALTH PLAN COMPARISON

Employees formerly covered by MCEA, MCJEA, MCDA, ONA, and Unrepresented employee groups.

For a complete description of benefits, refer to the carrier's benefit summary located on the Marion County website or contact the carrier directly. This is a summary of benefits only. Claims will be paid according to the carrier contract.

MEDICAL SERVICES	PacificSource HDHP* PPO** with HSA***		PacificSource Traditional PPO**		Kaiser HMO****
	In-Network	Out-of-Network	In-Network	Out-of-Network	Kaiser Facilities Only
Annual Deductible Deductible must be met before benefits are paid.	\$1,750 Employee Only / \$3,500 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
MEDICAL SERVICES	After Deductible Member Pays		After Deductible Member Pays		After Deductible Member Pays
Preventive: Well Baby Visits to age 2 Standard Immunizations Annual Exams	Paid in Full ¹	40% ¹	Paid in Full ¹	50%	Paid in Full
Office and Mental Health Visits	After ded, first 3 visits \$5 co-pay, then 20%	40%	First 3 visits \$5 co-pay ¹ , then \$15 co-pay ¹	50%	First 3 visits \$5 co-pay ¹ , then \$15 co-pay ¹
Naturopath & Specialist Visits	20%	40%	\$15 co-pay ¹ for visit	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 per test then deductible and 30%	\$100 copay, then deductible and 50%	\$100 per department visit ¹
Emergency Room Facility	20%		\$200 co-pay ¹ , then 30% Co-pay waived if admitted		\$200 co-pay after deductible (Waived if admitted)
Ambulance	20%		30%		20% co-insurance after deductible
Hospital Semi-Private Room & Board	20%	40%	\$100 co-pay ¹ per admit then 30%	\$100 co-pay ¹ Then 50%	\$100 per day up to \$500 per admittance
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% co-insurance after deductible
Outpatient Surgery	Hospital 20% Surgery Center 10%	40%	Hospital 30% Surgery Center 20%	40%	
Maternity Care Delivery covered as hospitalization	20%	40%	30%	50%	\$0 for scheduled Prenatal care and first Postpartum care
Skilled Nursing Facility Care	20%	40%	\$100 co-pay per admit then 30%	50%	\$0 up to 100 days per Calendar Year
Prescriptions (Rx)	In Network Pharmacy: Drugs on Preventive & Incentive Drug List: \$0, deductible waived ¹ https://pacificsource.com/drug-list/ Tier 1^, 2 and 3 Drugs: After deductible, 20%		In Network Pharmacy: Drugs on Preventive & Incentive Drug List: \$0, deductible waived. ¹ See list: https://pacificsource.com/drug-list/ Tier 1^: \$10, deductible waived Tier 2 ¹ : \$30, deductible waived Tier 3 ¹ : 50% deductible waived		<u>Generic:</u> \$10 co-pay ¹ <u>Preferred Brand:</u> \$30 co-pay ¹ <u>Formulary Contraceptives:</u> \$0 co-pay <u>Non-Preferred Brand/Specialty:</u> 50% co-insurance up to \$100 max <u>Mail order 90-day supply:</u> ² 90-day for two copayments; maintenance medications only
¹ Deductible Waived	Deductibles 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, co-payments, and coinsurance accrue toward the maximum out-of-pocket, except Alternative Care, Hearing Aids and Vision Hardware.				
Alternative Care Chiropractic and Acupuncture	20% in Network/40% out of Network \$1,500 combined annual max.		30% ¹ \$1,500 combined annual max.		\$40 ¹ Chiropractic up to 20 visits/year \$40 ¹ Acupuncture up to 12 visits/year \$25 ¹ Massage therapy up to 12 visits/year

VISION SERVICES	PacificSource HDHP* PPO**	PacificSource Traditional PPO**	Kaiser HMO****
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/	Please visit this website to locate approved providers: https://pacificsource.com/find-a-provider/	MUST USE KAISER FACILITIES
Routine Eye Exam	\$10 co-pay 1 Exam every 12 months with in-network provider ¹	\$10 co-pay 1 Exam every 12 months with in-network provider ¹	\$20 co-pay 1 Exam every 12 months with in-network provider ¹
Frames & Contact Lens	Not counted towards Out of Pocket Maximum	Up to \$200 maximum every 1 calendar year ¹	Up to \$200 maximum every 1 calendar year ¹
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 Lenses covered in full (excludes coatings)
DENTAL SERVICES	Delta Dental Plan	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 Dental, preventive services will not be counted towards annual maximum	Up to \$2,000 per Member per calendar year paid by Kaiser	
Preventive			
Routine Exam & X-Rays Prophylaxis (cleanings) Sealants & Fluoride Space Maintainers	0% (deductible waived), when seeking services from a 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 Kaiser 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	

2027 MONTHLY PREMIUM COSTS

Choice of Medical/Vision & Dental Plans	Subscriber Only	Subscriber + 1	Subscriber +2 or More	COBRA Members (includes all eligible family members)
Kaiser HMO	\$ 950.24	\$ 1,900.48	\$ 2,850.72	\$ 2,240.02
PacificSource Traditional PPO	\$ 1,053.31	\$ 2,037.02	\$ 3,075.07	\$ 2,397.71
PacificSource HDHP PPO with HSA	\$ 954.07	\$ 1,665.06	\$ 2,637.93	\$ 2,085.33
Kaiser Dental	\$ 62.85	\$ 125.69	\$ 188.54	\$ 144.27
Delta Dental	\$ 66.57	\$ 121.81	\$ 183.72	\$ 147.43

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 Account, may be paired with HDHP if you meet eligibility requirements.

PPO = Preferred Provider Organization (network) *HMO = Health Management Organization