2024 MARION COUNTY **RETIREE & COBRA** HEALTH PLAN COMPARISON

Formerly covered by MCEA, MCJEA, FOPPO or ONA Associations, Unit 12, 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 **https://www.co.marion.or.us/HR/Benefits/Pages/cobraretiree.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 contract.

MEDICAL SERVICES	**PacificSource HDHP* PPO** with HSA*** In-Network**	**PacificSource HDHP* PPO** with HSA*** Out-of-Network**	**PacificSource Traditional PPO** In-Network**	**PacificSource Traditional PPO** Out-of-Network**	**Kaiser HMO**** Kaiser Facilities Only**
Annual Deductible Deductible must be met before benefits are paid.	$1,500 Employee Only / $3,00 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
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 Visits (includes Mental Health and Naturopath)	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]
Specialist Visits	20%	40%	$15 co-pay1 for visit other services 30%	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 deducible 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%	$20
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		Generic: $10 co-pay[1] Preferred Brand: $30 co-pay[1] Formulary Contraceptives: $0 co-pay Non-Preferred Brand/Specialty: 50% co-insurance up to $100 max Mail order 90-day supply:[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, copayment and coinsurance amounts count 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 FACILTIES**
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 Endodontics (pulpal therapy & root canal filling) Restorative Fillings	**After Deductible Member Pays** 20% coinsurance	**After Deductible Member Pays** $0 for Restorative Fillings 20% for Endodontics
Major Crowns Cast Restorations Prosthetics (Dentures & Bridge Work)	**After Deductible Member Pays** 50% (Includes Oral Surgery & Periodontics)	**After Deductible Member Pays** 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

2024 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	$748.02	$1,496.05	$2,244.07	$1,761.03
PacificSource Traditional PPO	$808.34	$1,563.26	$2,359.90	$1,840.06
PacificSource HDHP PPO with HSA	$732.18	$1,277.82	$2,024.42	$1,600.36
Kaiser Dental	$55.52	$111.03	$166.55	$127.44
Delta Dental	$59.32	$108.54	$163.71	$131.38

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*

Rev.
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