2024 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 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 Health Savings Account (HSA)		PacificSource Health Traditional PPO (Preferred Provider Organization)		Kaiser HMO (Health Maintenance Organization)
	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	$1,600 Employee Only / $3,200 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
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)	After deductible first 3 visits covered in full. 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-pay[1] for visit **other services 30%**	50%	$30 co-pay[1]
Urgent Care Visits	20%	40%		50%	$40 co-pay[1]
Diagnostic Lab & X-Ray	20%	40%	30%[1]	50%	$15 co-pay per department visit[1]
High Cost Imaging (CT/ PET/MRI/scans)	20%	40%	$100 copay, then deductible 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%	Physical/Speech/Occupational-20 visits/year Chemo-no visit limit $30
Durable Medical Equip.	20%	40%	30%	50%	20% coinsurance after deductible
Outpatient Surgery	Hospital:20% Surgery Center: 10%	Hospital:40% 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[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	Chiropractic care up to 20 visits/year Accupuncture care up to 12 visits/year 20%	40%	Chiropractic care up to 20 visits/year[1] Accupuncture care up to 12 visits/year[1] 30%		$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

***** HDHP = High Deductible Health Plan

[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 Health Savings Account (HSA)**	**PacificSource Health Traditional PPO (Preferred Provider Organization)**	**Kaiser HMO (Health Maintenance Organization)**
	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 ONLY**
Routine Eye Exam	$10 co-pay 1 Exam every 12 months with in-network provider[1]	$10 co-pay 1 Exam every 12 months in-network provider[1]	$20 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.

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 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 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

Premiums include coverage for eligible family members. County premium cap is $1,646 for all except MCJEA (Juvenile Employees Association) with a cap of $1,696 and FOPPO (Parole & Probation Deputies) with a cap of $2,150.

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**	**All Others**	**MCJEA**	**FOPPO**	**All Others**
Kaiser HMO & Kaiser Dental	**$1,851.44**	**$1,646.00**	**$155.44**	**$0**	**$205.44**	**$77.72**	**$0**	**$102.72**
Kaiser HMO & Delta Dental	**$1,855.30**	**$1,646.00**	**$159.30**	**$0**	**$209.30**	**$79.65**	**$0**	**$104.65**
PacificSource PPO & Kaiser Dental	**$1,928.92**	**$1,646.00**	**$232.92**	**$0**	**$282.92**	**$116.46**	**$0**	**$141.46**
PacificSource PPO & Delta Dental	**$1,932.78**	**$1,646.00**	**$236.78**	**$0**	**$286.78**	**$118.39**	**$0**	**$143.39**
PacificSource HDHP & Kaiser Dental	**$1,693.92**	**$1,646.00**	**$0**	**$0**	**$47.92**	**$0**	**$0**	**$23.96**
PacificSource HDHP & Delta Dental	**$1,697.78**	**$1,646.00**	**$1.78**	**$0**	**$51.78**	**$0.89**	**$0**	**$25.89**

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.

Revised
10/18/2023