City of Eugene

CITY MANAGED CARE PLAN

Point of Service (POS)

SUMMARY OF HEALTH BENEFITS

Note: This is only a summary.
Please see your Benefits Handbook for complete details on benefits offered by the City of Eugene.

Effective January 1, 2012

MEDICAL BENEFIT SUMMARY

This is only a summary of your benefits; other sections of the handbook discuss the services covered under the plan, as well as applicable benefit limitations, exclusions from coverage, and conditions of service.

Payment to providers is based on the contracted reimbursement rate for covered services. Although in-network participating providers accept the contracted rate as payment in full, nonparticipating providers may not. To receive the maximum benefits under this plan, members should use an in-network participating provider and first seek treatment from their Primary Care Provider (PCP).

General Information	**Medical Coverage Administered by PacificSource Health Plans.**
Eligibility	Regular full-time and part-time employees scheduled to work at least 20 hours per week (or who otherwise qualify as regular part-time employees under an applicable labor agreement or administrative policy). IATSE-represented employee eligibility specified in most recent labor agreement between IATSE and the City of Eugene. Former employees and/or their dependents who are eligible for COBRA or the Retiree health insurance continuation.
When Coverage Begins	Active employees: First of the month following date of hire (following date of eligibility for IATSE-represented employees). COBRA/Retirees: First of the month following the last day of employment with the City of Eugene, provided timely election of coverage and premium payment.
Benefit Levels	The City Managed Care Plan uses the PacificSource Prime PSN Network. Benefit levels for most services referred by your PCP: • In-Network provider: Co-pay specified in this Medical Benefit Summary • Non-Network provider: 50% plus co-pay specified in this Medical Benefit Summary
Choice of Physician/Hospital	For most services, you must go to an in-network physician or hospital and have a referral from your primary care provider to receive in-network benefits. However, if you are willing to pay more for the cost of health care you may go to any qualified provider.
PacificSource Network Service Area	PacificSource contracts directly with participating providers throughout the Oregon and Idaho service areas and in Clark, Cowlitz, Klickitat, Pacific, Skamania, and Wahkiakum counties in southwest Washington. Members living outside the PacificSource network can receive in-network benefits through the Idaho Physician's Network, the Montana InterWest Health Network or the First Health Network.
Required Premiums	Employees may be required to contribute to the cost of coverage under this plan. Retiree and COBRA Continuees pay the full cost of the premium. Information on rates is available on the City of Eugene Benefits website at www.eugene-or.gov/employeebenefits.
Lifetime Maximum Benefit per Person	None
Calendar Year Out-of-Pocket Maximum Expense per Person *Mail order prescription drug co-pays do not count toward the Out of Pocket Maximum*	
AFSCME	Medical: $1,000 Retail pharmacy: $1,300
EPEA	Medical: $1,000 Retail pharmacy: $1,350
IAFF	Medical: $1,100 Retail pharmacy: $1,350
IATSE	Medical: $1,000 Retail pharmacy: $1,300
Non-Represented	Medical: $1,000 Retail pharmacy: $1,300

Service/Treatment/Supply	Co-pay	PCP or Referred Benefit After Co-pay	Nonparticipating or Nonreferred Benefit After Co-pay
Professional Services			
Alternative care (up to 12 visits per calendar year for all alternative care combined.)	$10 per visit –EPEA $15 per visit – Other Groups	100%	100%
Home and Office Visits	$10 per visit –EPEA $15 per visit – Other Groups	100%	50%
Outpatient Diabetic Instruction	$10 per visit –EPEA $15 per visit – Other Groups	100%	50%
Physician Hospital Visits	No co-pay	100%	50%
Surgery - Physician Services at a Facility	No co-pay	100%	50%
Surgery - Physician Services in the Physician's Office	$10 per visit –EPEA $15 per visit – Other Groups	100%	50%
Therapeutic Injections - Physician Services	No co-pay	100%	50%
Hospital / Inpatient Services			
Inpatient Room and Board*	$50 per day – AFSCME, EPEA and IATSE $60 - IAFF $100 per day - Non-Rep	100%	50%
Skilled Nursing Facility Care*	$50 per day - AFSCME, EPEA and IATSE $60 - IAFF $100 - Non-Rep	100%	50%
Outpatient Services			
Outpatient Surgery Facility Charges These services require pre-authorization	$20 per visit – AFSCME and IATSE $15 per visit – IAFF No co-pay – Other groups	100%	50%
X-ray and Lab - Diagnostic/Therapeutic	10% ($25 max) – AFSCME and IATSE $15 per visit – IAFF No co-pay – Other Groups	100%	50%
Imaging procedures (CT/MRI)	10% ($75 max) – AFSCME and IATSE $15 per visit – IAFF No co-pay – Other Groups	100%	50%
Emergency and Urgent Care			
Ambulance Transportation (co-pay waived if covered hospitalization immediately follows ambulance transport)	$50	100%	100%
Emergency Room Facility (co-pay waived if covered hospitalization immediately follows emergency room use)	$100 per visit – Non-Rep and IATSE $60 per visit – IAFF $50 per visit – EPEA $100 per visit, or $15 if referred by PCP to participating hospital but not admitted -AFSCME	100%	50%
Urgent Care Office Visit	$10 per visit – EPEA $15 per visit – Other Groups	100%	50%

Service/Treatment/Supply	Co-pay	PCP or Referred Benefit After Co-pay	Nonparticipating or Nonreferred Benefit After Co-pay
Rehabilitation			
Inpatient Rehabilitation*	$50 per day - AFSCME, EPEA and IATSE $60 per day - IAFF $100 per day - Non-Rep	100%	50%
Outpatient Rehabilitation	$10 per visit – EPEA $15 per visit – Other Groups	100%	50%
Physical Therapy, Speech Therapy and Occupational Therapy	$10 per visit – EPEA $15 per visit – Other Groups	100%	50%
Preventative Services			
Routine Physical Exams	$10 per visit – EPEA $15 per visit – Other Groups	100%	50%
Annual Gynecological Exams	$10 per visit – EPEA $15 per visit – Other Groups	100%	50%
Routine Mammograms	No co-pay	100%	50%
Cancer Screenings - including Colorectal and Prostate screening (subject to exam frequency limits)	$10 per visit – EPEA $15 per visit – Other Groups	100%	50%
Immunizations	No co-pay	100%	50%
Hearing/Eye Exams - Children (1 exam every 24 months for children through age 18)	$10 per visit – EPEA $15 per visit – Other Groups	100%	50%
Well-Baby Care	$10 per visit –EPEA $15 per visit – Other Groups	100%	50%
Other Services and Supplies			
Diabetic Supplies (other than insulin and syringes)	No co-pay	80%	50%
Durable Medical Equipment	No co-pay	80%	50%
Hospice Care	No co-pay ($15,000 life time maximum)	100%	50%
Home Healthcare	No co-pay	100%	50%
Home Infusion Therapy	No co-pay	100%	50%
Hearing Aid - Adults Maximum in a 36-month period: $500 – EPEA, Non-Rep and IAFF $1000 – AFSCME and IATSE	No co-pay	50%	50%
Hearing Aid - Children Maximum in a 48-month period: $4,000 – All Groups	No co-pay	80%	80%
Infertility**	No co-pay	50%	Not Covered
Injectable Medication			

Service/Treatment/Supply	Co-pay	PCP or Referred Benefit After Co-pay	Nonparticipating or Nonreferred Benefit After Co-pay
Self-administered	See Pharmacy Benefit Summary		
Provider-administered	No co-pay	100%	50%
Maternity / Pregnancy			
Physician services	$25 per pregnancy	100%	50%
Facility charges*	$50 per day – AFSCME, EPEA and IATSE $60 – IAFF $100 – Non-Rep	100%	50%
Mental Health and Chemical Dependency			
Inpatient*	$50 per day – AFSCME, EPEA and IATSE $60 – IAFF $100 – Non-Rep	100%	50%
Residential*	$50 per day – AFSCME, EPEA and IATSE $60 – IAFF $100 – Non-Rep	100%	50%
Outpatient	$10 per visit –EPEA $15 per visit – Other Groups	100%	50%
Prosthetic Devices	No co-pay	80%	50%
Tobacco Cessation Eligible expenses for members age 15 or older participating in a tobacco cessation program	No co-pay	$500 lifetime maximum benefit	$500 lifetime maximum benefit
Temporomandibular Joint Syndrome (TMJ) **	No co-pay	50%	Not Covered

*Co-pay subject to five day maximum
**Subject to limitations

PHARMACY BENEFIT SUMMARY

Pharmacy coverage is administered by PacificSource Health Plans, using the PacificSource Retail Pharmacy Network and offering mail-order pharmacy through your choice of CVS/Caremark or Wellpartner.

This health plan includes coverage for prescription drugs and contraceptives, subject to the limitations and exclusions. Please review the Covered Medical Services, Supplies and Treatments - Prescription Drug Program section of this handbook for more information.

The City of Eugene uses the PacificSource Preferred Drug List (PDL), which is available on the PacificSource website at: http://pacificsource.com/member/pacificsource-drug-list.pdf.

	Retail Co-pay	**Mail-Order Co-pay**
AFSCME-Represented	Up to 34-day supply (30-day supply for self-injectables) $1,300 Out of Pocket Maximum	Up to 100-day supply (30-days supply for self-injectables) No Out of Pocket Maximum
Generic (Tier 1): Preferred (Tier 2): Non-Preferred (Tier 3):	50% 50% $20 or 50%*	$20 $20 $30 or 25%* ($60 cap)
EPEA-Represented	Up to 34-day supply (30-day supply for self-injectables) $1,350 Out of Pocket Maximum	Up to 90-day supply (30-days supply for self-injectables No Out of Pocket Maximum)
Generic (Tier 1): Preferred (Tier 2): Non-Preferred (Tier 3):	$10 or 50%* $25 or 50%* $40 or 50%*	$15 $25 $50
IAFF-Represented	Up to 34-day supply (30-day supply for self-injectables) $1,350 Out of Pocket Maximum	Up to 90-day supply (30-days supply for self-injectables) No Out of Pocket Maximum
Generic (Tier 1): Preferred (Tier 2): Non-Preferred (Tier 3):	$10 or 50%* $25 or 50%* $40 or 50%*	$15 $25 $50
IATSE-Represented	Up to 34-day supply (30-day supply for self-injectables) $1,300 Out of Pocket Maximum	Up to 90-day supply (30-days supply for self-injectables) No Out of Pocket Maximum
Generic (Tier 1): Preferred (Tier 2): Non-Preferred (Tier 3):	50% 50% $40 or 50%*	$15 $35 $70
Non-Represented	Up to 34-day supply (30-day supply for self-injectables) $1,300 Out of Pocket Maximum	Up to 90-day supply (30-days supply for self-injectables) No Out of Pocket Maximum
Generic (Tier 1): Preferred (Tier 2): Non-Preferred (Tier 3):	50% 50% $40 or 50%*	$15 $35 $70

Whichever is greater

VISION BENEFIT SUMMARY

Former Employees: Vision Coverage is optional for former employees continuing coverage, and is only available if you selected this benefit level and pay the additional required premium.

Vision coverage is administered by PacificSource Health Plans.

See the Vision Plan Coverage section of this handbook for additional information about your benefits.

VISION GENERAL INFORMATION		
Deductible	None	
Covered Vision Services	Exams, lenses and frames, contact lenses, medically necessary subnormal vision aids	
BENEFIT	**IATSE**	**IAFF and EPEA**
Eye Exams (once every 12 months)	80% up to $60	80% up to $75
Lenses (per lens)*** Single Vision Bifocal Trifocal Lenticular	 $20 $30 $40 $60	 $25 $40 $40 $60
Frames*** (one pair, once every 24 months)	$50	$60
Contacts*** (per lens, once every 24 months) After cataract surgery To correct extreme visual acuity problems (20/70) Cosmetic Contacts (both lenses)	$60 $60 $70	$75 $75 $90
***Plan members are eligible for prescription lenses and frames **OR** prescription contacts every 24 consecutive months.		
BENEFIT	**AFSCME and Non-Represented**	
Eye Exams (once every 12 months)	80%	
Prescription frames, lenses and/or contacts (once every 24 months)	$150 maximum	

DENTAL BENEFIT SUMMARY

Former Employees: Dental Coverage is optional for former employees continuing coverage, and is only available if you selected this benefit level and pay the additional required premium.

Dental coverage is administered by Oregon Dental Service (ODS).

This is only a brief summary of your dental benefits. Please refer to the additional information provided in the Dental Coverage section of this handbook for details.

The City's dental plan utilizes the ODS Premier Dental Network. ODS has contracted with participating dentists and has approved their fee schedules. As a result, your share of the dental costs may be reduced. Benefit levels for non-participating providers are based on the prevailing fee level charged by other dentists for the same services.

BENEFIT	
ODS Dental Network Service Area	The ODS Premier Dental Network includes all counties in Oregon. Members living outside the ODS Premier Dental Network can receive in-network benefits from a Premier provider through ODS' nationwide network, the Delta Dental Network.
Calendar Year Deductible	AFSCME-, IAFF-, IATSE- and Non-Represented: $50 per person; $150 family maximum EPEA-represented group: $25 per person; $75 family maximum
Maximum Dental Benefit	EPEA-, and IATSE-Represented: $250 per person for expenses incurred first calendar year of eligibility; $1,250 per person each calendar year thereafter AFSCME-Represented: $250 per person for expenses incurred first calendar year of eligibility; $1,500 per person each calendar year thereafter IAFF-Represented: $300 per person for expenses incurred first calendar year of eligibility; $1,300 per person each calendar year thereafter Non-Represented: $1,500 per person each calendar year Essential dental benefits for members under the age of 16 will not be subject to the annual dental maximum. See the Dental Plan Coverage section of this handbook for details.
Preventative Services Exams, Bitewing X-rays, Fluoride, Cleaning	100% no deductible
Basic Services Fillings, Crowns, Denture Repairs	80% after deductible
Major Services Initial Dentures and Bridgework	50% after deductible
Dental Implants	Non-Represented: 50% after deductible. Implant placement and removal once per lifetime per tooth space. Others: Not covered
Orthodontic Services	50% no deductible. $2,000 per person maximum lifetime benefit