

City of Eugene



Summary of Health Benefits

CITY MANAGED CARE PLAN

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

Updated March 15, 2021

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.

General Information	Medical Coverage Administered by PacificSource Health Plans.
Eligibility	<p>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.</p> <p>Temporary employees meeting the definition of full-time under the Affordable Care Act (ACA).</p> <p>Former employees and/or their dependents who are eligible for COBRA or the Retiree health insurance continuation.</p>
When Coverage Begins	<p>Regular Active employees: First of the month following date of hire (following date of eligibility for IATSE-represented employees). Temporary Active employees: First of the month after the Administrative Period following ACA date of eligibility.</p> <p>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.</p>
Benefit Levels	<p>The City Managed Care Plan uses the PacificSource Voyager Network. Benefit levels for most services are:</p> <ul style="list-style-type: none"> • 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	<p>For most services, you must go to an in-network physician or hospital 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.</p>
Service Area	<p>Worldwide for emergencies. Benefits are paid at the highest rate when using a provider in the PacificSource service area. PacificSource contracts with participating providers throughout the Oregon, Idaho, and Montana service areas and in bordering communities in southwest Washington. They also have agreements with certain nationwide networks whose providers outside the PacificSource service area are considered participating providers under your plan. Contact PacificSource for details.</p> <p>Contact PacificSource for information on contracted air ambulance services.</p>
Required Premiums	<p>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.</p>
Calendar Year Out-of-Pocket Maximum Expense per Person	
AFSCME-Represented	<p>Medical: \$1,000 per person Pharmacy: \$1,300 per person</p>
EPEA-Represented	<p>Medical: \$1,100 per person Pharmacy: \$1,350 per person</p>
IAFF-Represented	<p>Medical: \$1,100 per person Pharmacy: \$1,350 per person</p>
IATSE-Represented	<p>Medical: \$1,000 per person Pharmacy: \$1,300 per person</p>
IAFF-BC and Non-Represented	<p>Medical: \$1,000 per person Pharmacy: \$1,300 per person</p>

Service/Treatment/Supply	Co-pay	In-Network Benefit After Co-pay	Out of Network Benefit After Co-pay
COVID-19 Temporary Provisions: The City of Eugene is temporarily waiving copays, co-insurance, and deductibles for approved services below. These temporary provisions will remain in effect until further notice from the City of Eugene			
FDA approved or authorized COVID-19 testing and diagnosis related visits	No co-pay	100%	100%
FDA approved or authorized COVID-19 vaccination and vaccination administration	No co-pay	100%	100%
Teladoc medical and behavioral health telehealth visits accessed through PacificSource	No co-pay	100%	N/A
Preventative Services <i>IATSE-Represented employees have certain women's preventative care services covered with no co-pay as outlined by the Affordable Care Act as it applies to Non-Grandfathered plans. Please contact PacificSource for details.</i>			
Routine Physical Exams	\$15 per visit –EPEA No co-pay - AFSCME, IATSE and Non-Represented \$15 per visit – IAFF, IAFF-BC	100%	50%
Annual Gynecological Exams	\$15 per visit –EPEA No co-pay - AFSCME, IATSE and Non-Represented \$15 per visit – IAFF, IAFF-BC	100%	50%
Routine Mammograms	No co-pay	100%	50%
Cancer Screenings - including Colorectal and Prostate screening (subject to exam frequency limits)	\$15 per visit –EPEA No co-pay - AFSCME, IATSE and Non-Represented \$15 per visit – IAFF, IAFF-BC	100%	50%
Preventative Care Lab Services	\$15 per visit –EPEA No co-pay - AFSCME, IATSE and Non-Represented \$15 per visit – IAFF, IAFF-BC	100%	50%
Immunizations	No co-pay	100%	50%
Hearing/Eye Exams - Children (1 exam every 24 months for children through age 18)	\$15 per visit –EPEA \$20 per visit – AFSCME No co-pay - IATSE \$15 per visit – IAFF, IAFF-BC and Non-Represented	100%	50%
Well-Baby Care	\$15 per visit –EPEA No co-pay - AFSCME, IATSE and Non-Represented \$15 per visit – IAFF, IAFF-BC	100%	50%
Professional Services			
Alternative care Up to 12 visits (15 visits for Non-Represented) per calendar year for all alternative care combined.	\$15 per visit –EPEA \$20 per visit – AFSCME \$25 per visit - IATSE \$15 per visit – IAFF, IAFF-BC and Non-Represented	100%	100%
Home and Office Visits	\$15 per visit –EPEA \$20 per visit – AFSCME \$25 per visit - IATSE \$15 per visit – IAFF, IAFF-BC and Non-Represented	100%	50%

Service/Treatment/Supply	Co-pay	In-Network Benefit After Co-pay	Out of Network Benefit After Co-pay
Outpatient Diabetic Instruction	\$15 per visit –EPEA \$20 per visit – AFSCME \$25 per visit - IATSE \$15 per visit – IAFF, IAFF-BC and Non-Represented	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	\$15 per visit –EPEA \$20 per visit – AFSCME \$25 per visit - IATSE \$15 per visit – IAFF, IAFF-BC and Non-Represented	100%	50%
Therapeutic Injections - Physician Services	No co-pay	100%	50%
Hospital / Inpatient Services			
Inpatient Room and Board*	\$50 per day – AFSCME and IATSE \$60 per day – EPEA and IAFF \$100 per day- IAFF-BC and Non-Represented	100%	50%
Skilled Nursing Facility Care*	\$50 per day -AFSCME and IATSE \$60 per day - EPEA and IAFF \$100 per day - IAFF-BC and Non-Represented	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 – EPEA, IAFF-BC and Non-Represented	100%	50%
X-ray and Lab - Diagnostic/Therapeutic	10% (\$25 max) – AFSCME and IATSE \$15 per visit – IAFF No co-pay – EPEA, IAFF-BC and Non-Represented	100%	50%
Imaging procedures (CT/MRI)	10% (\$75 max) – AFSCME and IATSE \$15 per visit – IAFF No co-pay – EPEA, IAFF-BC and Non-Represented	100%	50%
Emergency and Urgent Care			
Ambulance Transportation (Co-pay waived if covered hospitalization immediately follows ambulance transport.) Contact PacificSource for information on contracted air ambulance services.	\$50	100%	100%
Emergency Room Facility (Co-pay waived if covered hospitalization immediately follows emergency room use.)	\$100 per visit – IATSE, IAFF-BC and Non-Represented \$60 per visit – EPEA and IAFF \$100 per visit, or \$20 if referred by PCP to participating hospital but not admitted – AFSCME	100%	100% - IATSE 50% - Other Groups
Urgent Care Office Visit	\$20 per visit – AFSCME \$15 per visit –EPEA \$25 per visit - IATSE \$15 per visit – IAFF, IAFF-BC and Non-Represented	100%	50%
Rehabilitation			

Service/Treatment/Supply	Co-pay	In-Network Benefit After Co-pay	Out of Network Benefit After Co-pay
Inpatient Rehabilitation*	\$50 per day - AFSCME and IATSE \$60 per day – EPEA and IAFF \$100 per day – IAFF-BC and Non-Represented	100%	50%
Outpatient Rehabilitation	\$15 per visit –EPEA \$20 per visit – AFSCME \$25 per visit - IATSE \$15 per visit – IAFF, IAFF-BC and Non-Represented	100%	50%
Physical Therapy, Speech Therapy and Occupational Therapy	\$15 per visit –EPEA \$20 per visit – AFSCME \$25 per visit - IATSE \$15 per visit – IAFF, IAFF-BC and Non-Represented	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	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, IAFF and IAFF-BC \$1000 – AFSCME, IATSE and Non-Represented	No co-pay	50%	50%
Hearing Aid - Children	No co-pay	80%	80%
Infertility**	No co-pay	50%	Not Covered
Injectable Medication			
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 and IATSE \$60 per day – EPEA and IAFF \$100 per day – IAFF-BC and Non-Represented	100%	50%
Mental Health and Chemical Dependency			
Inpatient*	\$50 per day - AFSCME and IATSE \$60 per day – EPEA and IAFF \$100 per day - IAFF-BC and Non-Represented	100%	50%
Residential*	\$50 per day - AFSCME and IATSE \$60 per day – EPEA and IAFF \$100 per day - IAFF-BC and Non-Represented	100%	50%
Outpatient	\$15 per visit –EPEA \$20 per visit – AFSCME \$25 per visit - IATSE \$15 per visit – IAFF, IAFF-BC and Non-Represented	100%	50%

Service/Treatment/Supply	Co-pay	In-Network Benefit After Co-pay	Out of Network Benefit After Co-pay
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	100%	100%
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 CVS Caremark.

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 complies with the Affordable Care Act as it applies to 100% coverage of preventative drugs outlined in the Act. Please contact PacificSource for details.

The City of Eugene uses the PacificSource Preferred Drug List (PDL), which is available on the PacificSource website at: <http://www.pacificsource.com/pdl/>.

	Retail Co-pay <i>Copay charged for each 34-day supply</i>	Mail-Order Co-pay
AFSCME-Represented	Up to 90-day supply** (30-day supply for self-injectables)	Up to 100-day supply** (30-day supply for self-injectables)
Tier 1:	50%	\$20
Tier 2:	50%	\$20
Tier 3:	\$20 or 50%*	\$30 or 25%* (\$60 cap)
EPEA-Represented	Up to 90-day supply** (30-day supply for self-injectables)	Up to 90-day supply** (30-day supply for self-injectables)
Tier 1:	\$10 or 50%*	\$15
Tier 2:	\$25 or 50%*	\$25
Tier 3:	\$40 or 50%*	\$50
IAFF-Represented	Up to 90-day supply** (30-day supply for self-injectables)	Up to 90-day supply** (30-day supply for self-injectables)
Tier 1:	\$10 or 50%*	\$15
Tier 2:	\$25 or 50%*	\$25
Tier 3:	\$40 or 50%*	\$50
IATSE-Represented	Up to 90-day supply** (30-day supply for self-injectables)	Up to 90-day supply** (30-day supply for self-injectables)
Tier 1:	50%	\$15
Tier 2:	50%	\$35
Tier 3:	\$40 or 50%*	\$70
IAFF-BC and Non-Represented	Up to 90-day supply** (30-day supply for self-injectables)	Up to 90-day supply** (30-day supply for self-injectables)
Tier 1:	50%	\$15
Tier 2:	50%	\$35
Tier 3:	\$40 or 50%*	\$70

**Whichever is greater*

***If a 3-month supply of contraceptives is initially prescribed, a 12-month refill of the same contraceptive will be covered, regardless if the initial prescription was covered under this plan.*

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 – Children under the age of 19	All Plans	
Eye Exams (once every 12 months)	80%	
Prescription frames and lenses OR contacts (once every 12 months). Contacts limited to the following per year: Standard (one pair annually): 1 contact lens per eye (2 lenses total); Monthly (six month supply) or Biweekly (3 month supply): 6 lenses per eye (12 lenses total); Dailies (one month supply): 30 lenses per eye (60 lenses total)	100%	
BENEFIT - Adults	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
***Adult plan members are eligible for prescription lenses and frames OR prescription contacts every 24 consecutive months.		
BENEFIT - Adults	IAFF BC	AFSCME- and Non-Represented
Eye Exams (once every 12 months)	80%	80%
Prescription frames, lenses and/or contacts (once every 24 months)	\$150 maximum	\$300 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 Delta Dental Plan of Oregon, a Moda Health affiliated company.

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 Delta Dental Premier Dental Network. Delta Dental 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	
Delta Dental Network Service Area	The Delta Dental Premier Dental Network includes all counties in Oregon. Members living outside the Delta Dental Premier Dental Network can receive in-network benefits from a Premier provider through Delta Dental's nationwide network, the Delta Dental Network.
Calendar Year Deductible	AFSCME-, IAFF-, IAFF BC, IATSE- and Non-Represented: \$50 per person; \$150 family maximum EPEA-represented group: \$30 per person; \$100 family maximum
Maximum Dental Benefit*	AFSCME-Represented: \$250 per person for expenses incurred first calendar year of eligibility; \$1,600 per person each calendar year thereafter IATSE-Represented: \$250 per person for expenses incurred first calendar year of eligibility; \$1,250 per person each calendar year thereafter EPEA- and IAFF-Represented: \$300 per person for expenses incurred first calendar year of eligibility; \$1,300 per person each calendar year thereafter IAFF BC and Non-Represented: \$1,500 per person each calendar year *Essential dental benefits for members under the age of 19 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	AFSCME-, IAFF BC and Non-Represented: 50% after deductible. Implant placement and removal once per lifetime per tooth space. AFSCME benefit not subject to annual benefit maximum through June 30, 2021, after which benefit will be subject to the annual benefit maximum. Others: Not covered
Orthodontic Services	50% no deductible. \$2,000 per person maximum lifetime benefit