City of Eugene

Summary of Health Benefits

CITY HYBRID PLAN

Point of Service (POS)

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.

The City Hybrid Plan requires either a co-pay for services or a deductible and co-insurance amount as the member's contribution to the cost of services under the plan. **Services requiring a co-insurance amount are paid after the deductible has been met.** The deductible does not apply for services requiring a co-pay.

General Information	**Medical Coverage Administered by PacificSource Health Plans.**
Eligibility	Regular AFSCME- and Non-Represented full-time and part-time employees scheduled to work at least 20 hours per week (or who otherwise qualify 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. Temporary employees meeting the definition of full-time under the Affordable Care Act (ACA). Former AFSCME-, IATSE- and Non-Represented employees and/or their dependents who are eligible for COBRA or the Retiree health insurance continuation.
When Coverage Begins	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. 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 Hybrid Plan uses the PacificSource Voyager Network. Benefit levels for *most* services are: • In-Network provider: The co-pay **or** co-insurance and deductible as specified in this Medical Benefit Summary • Non-Network provider: Normally, 50% plus co-pay **or** 50% plus co-insurance and deductible as specified in this Medical Benefit Summary
Choice of Physician/Hospital	For most services, you must go to an in-network physician or hospital 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.
Service Area	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. Contact PacificSource for information on contracted air ambulance services.
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.

Calendar Year Medical Deductible (only applies to services requiring co-insurance as outlined below)	
AFSCME-, IATSE- and Non-Represented	Per Person: $200 Per Family: $600
Calendar Year Out-of-Pocket Maximum Expense per Person	
AFSCME- and Non-Represented	Medical: $1,000 per person Pharmacy: $1,300 per person Deductibles and fixed dollar copays do not count toward the Out of Pocket Maximum
IATSE-Represented	Medical: $1,200 per person, including deductible. (No more than three deductibles apply per family per year) Pharmacy: $1,300 per person Fixed dollar co-pays for services that are not considered Essential Health Benefits do not count toward the Out of Pocket Maximum.

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% no deductible	100% no deductible
FDA approved or authorized COVID-19 vaccination and vaccination administration	No co-pay	100% no deductible	100% no deductible
Teladoc medical and behavioral health telehealth visits accessed through PacificSource	No co-pay	100% no deductible	N/A
Preventative Services *Note: 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 health plans. Please contact PacificSource for details.*			
Routine Physical Exams	No co-pay	100% no deductible	50% no deductible
Annual Gynecological Exams	No co-pay	100% no deductible	50% no deductible
Routine Mammograms	No co-pay	100% no deductible	50% no deductible
Cancer Screenings - including Colorectal and Prostate screening (subject to exam frequency limits)	No co-pay	100% no deductible	50% no deductible
Preventative Care Lab Services	No co-pay	100% no deductible	50% no deductible
Immunizations	No co-pay	100% no deductible	50% no deductible

Service/Treatment/Supply	Co-pay	In-Network Benefit After Co-pay	Out of Network Benefit After Co-pay
Hearing/Eye Exams - Children (1 exam every 24 months for children through age 18)	No co-pay – IATSE-Represented $15 per visit – AFSCME- and Non-Represented	100% no deductible	50% no deductible
Well-Baby Care	No co-pay	100% no deductible	50% no deductible
Professional Services			
Alternative care Per calendar year for all alternative care combined: IATSE- up to 12 visits / AFSCME- and Non-Represented - up to 15 visits	$25 per visit – IATSE-Represented $15 per visit – AFSCME- and Non-Represented	100% no deductible	100% no deductible
Home and Office Visits	$25 per visit – IATSE-Represented $15 per visit – AFSCME- and Non-Represented	100% no deductible	50% no deductible
Outpatient Diabetic Instruction	$25 per visit – IATSE-Represented $15 per visit – AFSCME- and Non-Represented	100% no deductible	50% no deductible
Physician Hospital Visits	No co-pay	80% after deductible	50% after deductible
Surgery - Physician Services at a Facility	No co-pay	80% after deductible	50% after deductible
Surgery - Physician Services in the Physician’s Office	$25 per visit – IATSE-Represented $15 per visit – AFSCME- and Non-Represented	100% no deductible	50% no deductible
Therapeutic Injections - Physician Services	No co-pay	80% after deductible	50% after deductible
Hospital / Inpatient Services			
Inpatient Room and Board*	$100 per day	100% for first five days, then 80% after deductible	50% for first five days, then 50% after deductible
Skilled Nursing Facility Care*	$100 per day	100% for first five days, then 80% after deductible	50% for first five days, then 50% after deductible
Outpatient Services			
Outpatient Surgery Facility Charges These services require pre-authorization	No co-pay	80% after deductible	50% after deductible
X-ray and Lab - Diagnostic/Therapeutic	No co-pay	80% after deductible	50% after deductible
Imaging procedures (CT/MRI)	No co-pay	80% after deductible	50% after deductible
Emergency and Urgent Care			
Ambulance Transportation Contact PacificSource for information on contracted air ambulance services.	No co-pay	80% after deductible	80% after deductible

Service/Treatment/Supply	Co-pay	In-Network Benefit After Co-pay	Out of Network Benefit After Co-pay
Emergency Room Facility (co-pay waived if covered hospitalization immediately follows emergency room use).	$100 per visit	100% no deductible	100% no deductible - IATSE-Represented 50% no deductible - AFSCME- and Non-Represented
Urgent Care Office Visit	$25 per visit – IATSE-Represented $15 per visit – AFSCME- and Non-Represented	100% no deductible	50% no deductible
Rehabilitation			
Inpatient Rehabilitation*	$100 per day	100% for first five days, then 80% after deductible	50% for first five days, then 50% after deductible
Outpatient Rehabilitation	$25 per visit – IATSE-Represented $15 per visit – AFSCME- and Non-Represented	100% no deductible	50% no deductible
Physical Therapy, Speech Therapy and Occupational Therapy	$25 per visit – IATSE-Represented $15 per visit – AFSCME- and Non-Represented	100% no deductible	50% no deductible
Other Services and Supplies			
Diabetic Supplies (other than insulin and syringes)	No co-pay	80% after deductible	50% after deductible
Durable Medical Equipment	No co-pay	80% after deductible	50% after deductible
Hearing Aid - Adults $1000 maximum in a 36-month period	No co-pay	50% after deductible	50% after deductible
Hearing Aid - Children	No co-pay	80% after deductible	80% after deductible
Home Healthcare	No co-pay	80% after deductible	50% after deductible
Home Infusion Therapy	No co-pay	100%	50%
Hospice Care	No co-pay	80% after deductible	50% after deductible
Infertility**	No co-pay	50% after deductible	Not Covered
Injectable Medication			
Self-administered	See Pharmacy Benefit Summary		
Provider-administered	No co-pay	100% no deductible	50% no deductible
Maternity / Pregnancy			
Physician services	No co-pay – IATSE-Represented $15 per visit – AFSCME- and Non-Represented	80% after deductible - IATSE-Represented 100% no deductible - AFSCME- and Non-Represented	80% after deductible - IATSE-Represented 50% no deductible - AFSCME- and Non-Represented
Facility charges*	$100 per day	80% after deductible	50% after deductible
Mental Health and Chemical Dependency			
Inpatient*	$100 per day	100% for first five days, then 80% after deductible	50% for first five days, then 50% after deductible

Service/Treatment/Supply	Co-pay	In-Network Benefit After Co-pay	Out of Network Benefit After Co-pay
Residential*	$100 per day	100% for first five days, then 80% after deductible	50% for first five days, then 50% after deductible
Outpatient	$25 per visit – IATSE-Represented $15 per visit – AFSCME- and Non-Represented	100% no deductible	50% no deductible
Prosthetic Devices	No co-pay	80% after deductible	50% after deductible
Temporomandibular Joint Syndrome (TMJ) **	No co-pay	50% after deductible	Not Covered
Tobacco Cessation Eligible expenses for members age 15 or older participating in a tobacco cessation program	No co-pay	100% no deductible	100% no deductible

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

PHARMACY BENEFIT SUMMARY

Pharmacy coverage is administered by PacificSource Health Plans, and uses the PacificSource Health Plans Retail Pharmacy Network and offers 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 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 at: http://www.pacificsource.com/pdl/.

	Retail Co-pay ***Copay charged for each 34-day supply***	**Mail-Order Co-pay**
IATSE-Represented	Up to 34-day supply* (30-day supply for self-injectables)	Up to 90-day supply* (30-day supply for self-injectables)
Tier 1: Tier 2: Tier 3:	50% 50% $40 or 50%, W*hichever is greater*	$15 $35 $70
AFSCME- and Non-Represented	Up to 34-day supply* (30-day supply for self-injectables)	Up to 90-day supply* (30-day supply for self-injectables)
Tier 1: Tier 2: Tier 3:	50% 50% $40 or 50%, W*hichever is greater*	$15 $35 $70

**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	
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-Represented**
Eye Exams (once every 12 months)	80% up to $60
Lenses (per lens)* Single Vision Bifocal Trifocal Lenticular	 $20 $30 $40 $60
Frames* (one pair, once every 24 months)	$50
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
*Adult IATSE plan members are eligible for prescription lenses and frames **OR** prescription contacts every 24 consecutive months.	
BENEFIT - Adults	**AFSCME- and Non-Represented**
Eye Exams (once every 12 months)	80%
Prescription frames, lenses and/or contacts (once every 24 months)	$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, 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 Hybrid 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	**Dental coverage is administered by Delta Dental of Oregon**
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' nationwide network, the Delta Dental Network.
Calendar Year Deductible	$50 per person; $150 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 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- 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. IATSE-Represented: Not covered
Orthodontic Services	50% no deductible. $2,000 per person maximum lifetime benefit