COMPARISON OF BENEFITS*
FOR CITY OF EUGENE
AFSCME-REPRESENTED EMPLOYEES

Effective July 1, 2022

This comparison of benefits summarizes the general benefits under each plan and does not provide a full description of benefits. The benefits outlined assume plan members receive eligible In-Network services. Services may require pre-authorization or have other limitations that may not be included in this document.

For further information please review your handbook at https://eugene-or.gov/2399/Basic-Info-Handbooks-Rates, or contact our administrators, PacificSource Health Plans for medical, pharmacy or vision benefits or Delta Dental for dental benefits.

Benefits - AFSCME	City Health Plan In-Network Benefit	City Managed Care Plan In-Network Benefit	City Hybrid Plan** In-Network Benefit
General Information			
Payroll Deduction	Full-time Regular employees: Individual: $72.64 per month Two-Party: $137.67 per month Family: $191.88 per month	Full-time Regular employees: Individual: $58.93 per month Two-Party: $119.24 per month Family: $173.99 per month	Full-time Regular employees: Individual: $28.74 per month Two-Party: $58.14 per month Family: $84.84 per month
	Employees may Opt-Out of health insurance with proof of other coverage.		
Eligible Dependents	Spouse or domestic partner. Eligible children up to age 26.		
Benefit Levels	Most benefit levels after the deductible are: In-Network provider: 80% of discounted rates; Non-Network provider: 50% of reasonable and customary charges.	Benefits are paid at the highest level when using in-network providers. Most Non-Network provider benefits are 50% of reasonable and customary charges after co-pay.	Benefits are paid at the highest level when using in-network providers. Most Non-Network provider benefits are 50% of reasonable and customary charges after co-pay.
Service Area	Worldwide	Worldwide for emergencies	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.		
Choice of Physician	Any qualified physician. While in the service area, you must use a network provider or hospital to receive in-network benefits.		
Calendar Year Medical and Dental Deductibles	All benefits paid after the deductible is met unless otherwise noted. Medical: $150 per person; $450 maximum per family. Dental: $50 per person; $150 maximum per family.	All benefits paid after the deductible is met unless otherwise noted. Medical: No deductible. Dental: $50 per person; $150 maximum per family.	All benefits paid after the deductible is met unless otherwise noted. Medical: $200 per person; $600 maximum per family. Dental: $50 per person; $150 maximum per family.
Out-of-Pocket Medical Maximum	$850 per person per calendar year, in addition to the deductible, for covered Medical and Prescription expenses. Once this limit is met, eligible charges are covered in full for remainder of calendar year.	$1,000 per person each calendar year for covered expenses. Once this limit is met, eligible charges are covered in full for remainder of calendar year.	$1,000 per person each calendar year for covered medical expenses. Once this limit is met, eligible charges are covered in full for remainder of calendar year.

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Out-of-Pocket Rx Maximum	Combined Prescription and Medical Maximum Out of Pocket maximum (see above). Once this limit is met, eligible charges are covered in full for remainder of calendar year.	$1,300 per person each calendar year. Once this limit is met, eligible prescriptions will be covered in full for the remainder of the calendar year.	$1,300 per person each calendar year. Once this limit is met, eligible prescriptions will be covered in full for the remainder of the calendar year.
Annual Dental Benefit Maximum	First calendar year of coverage: $250*. Each succeeding calendar year: $1,600*. *Does not apply to essential dental benefits for members under age 19. See the Employee Benefits Handbook for details.		
Claims Filing	Claim forms, if needed, may be submitted by either the patient or the provider.		
For more information contact:	**PacificSource Health Plans: 541.684.5582 or 888.246.1370 (medical/vision/pharmacy)** **Delta Dental Plan of Oregon: 888.217.2365 (dental)** **Employee Resource Center Employee Benefits Program: 541.682.5061**		
Medical, Vision and Pharmacy Benefits – Administered by PacificSource Health Plans			
Physicians Services			
Surgery/Delivery			
Inpatient	80% after deductible.	Covered in full.	80% after deductible.
Outpatient	Physician services: 100% In-Network, no deductible. Facility Fee: 80% In-Network, no deductible.	$20 co-payment for professional services if performed in a physician's office. $20 co-payment for other Outpatient Surgery Services	$15 co-pay for professional services if performed in a physician's office. 80% after deductible for outpatient facility charges.
Office Visits	80% after deductible; 80% no deductible for treatment of accidental injury.	Covered in full after $20 co-payment per visit.	Covered in full after $15 co-pay per visit.
Hospital Visits	80% after deductible.	Covered in full.	80% after deductible.
Teladoc Medical and Behavioral Telehealth Physician Consults	Currently covered at 100% no deductible. After temporary waiver ends, 90% after deductible; 90% no deductible for treatment of accidental injury.	Currently covered in full with no co-pay. After temporary waiver ends, covered in full after $10 co-pay per visit.	Currently covered in full with no co-pay. After temporary waiver ends, covered in full after $10 co-pay per visit.
Allergy Injections	80% after deductible.	Covered in full.	80% after deductible.
Hospital Services			
Semi-private Room and Board	80% after deductible. *Subject to compliance with utilization review*	Covered in full after $50 co-payment per day ($250 maximum per stay).	$100 co-pay then 80% (co-pay limited to 5 days)
Emergency Care			
Within Service Area	80% after deductible for treatment of illness; 80% with no deductible for treatment of accidental injury.	$100 co-payment per visit; Co-payment waived if admitted.	$100 co-pay per visit; waived if admitted.

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Outside of Service Area	80% after deductible for treatment of illness. 80% with no deductible for treatment of accidental injury.	$100 co-payment per visit; waived if admitted.	$100 co-pay per visit; waived if admitted.
Emergency Transportation	100% no deductible.	$50 per trip; waived if admitted. Air ambulance covered when preauthorized.	80% after deductible.
Outpatient Services			
CT Scans and MRI	80% after deductible for illness; 80% no deductible for treatment of accidental injury.	10% co-payment with a $75 maximum.	80% after deductible
X-Ray, Lab Tests and Radiation Therapy	80% after deductible for illness; 80% no deductible for treatment of accidental injury.	10% co-payment with a $25 maximum.	80% after deductible
Rehabilitation - Physical Therapy	80% after deductible if prescribed by physician.	Covered in full after $20 co-pay per session if prescribed by physician. Limited to 30 sessions/yr (combined with Occupational & Speech Therapy). May require pre-authorization.	Covered in full after $15 co-pay if prescribed by physician. No deductible. Limited to 30 sessions/yr (combined with Occupational & Speech Therapy). May require pre-authorization.
Occupational and Speech Therapy	80% after deductible for certain medical conditions if prescribed by physician.	Covered in full after $20 co-pay per session. Limited to 30 sessions/year (combined with Physical Therapy). May require pre-authorization.	Covered in full after $15 co-pay per session. No deductible. Limited to 30 sessions/yr (combined with Physical Therapy). May require pre-authorization.
Maternity Care			
Hospital Services including Caesarean Sections and Newborn Care	Covered the same as any other medical condition; routine hospital nursery care covered from date of birth; 100% after deductible for delivery at licensed birthing center	Covered in full for outpatient delivery. Inpatient delivery covered in full after $50 co-payment per day ($250 maximum per stay).	$100 co-pay then 80% (co-pay limited to 5 days)
Physician Services including Prenatal, Delivery and Postnatal Care of Mother and Child	80% after deductible.	Covered in full after $25 co-payment per pregnancy.	Covered in full after $15 co-pay per visit.
Preventive and Well-Care Services			
Periodic Physical and Women's Gynecological Exams: including Breast, Pap and Pelvic Exams	Covered at 100%, no deductible.	Covered in full.	Covered in full. No deductible.

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Well-Baby/Child Care	Covered at 100%, no deductible (no visit limit through age 12 months, then subject to schedule recommended by Health Resources & Services Administration).	Covered in full (subject to schedule recommended by Health Resources & Services Administration).	Covered in full, no deductible (subject to schedule recommended by Health Resources & Services Administration).
Newborn Nurse Home Visiting Services	Covered at 100% no deductible up to age six months.	Covered in full up to age six months.	Covered in full up to age six months. No deductible.
Immunizations	Covered at 100% for adults and children; no deductible. Children covered under Well-Baby/Child Care.	Covered in full.	Covered in full. No deductible.
Cancer Screenings: including Colonoscopy and Mammography	Covered at 100%, no deductible. Subject to schedule of eligibility	Covered in full Subject to schedule of eligibility.	Covered in full. Subject to schedule of eligibility. No deductible.
Other Medical Treatment			
Alternative Care	Acupuncture: 80% after deductible. Chiropractor: 80% after deductible, limited to 52 visits a calendar year. Office visits to Licensed Naturopaths ($300 benefit max), Licensed Massage Therapists ($300 benefit max), and Registered Dietitians ($200 benefit max): 80% after deductible. Benefit maximums per calendar year as noted. No limitation on number of medically necessary visits.	Services of Licensed Chiropractors, Licensed Massage Therapists, Registered Acupuncturists & Registered Dieticians; and office visits to Licensed Naturopaths: $20 co-payment per visit, up to 12 visits combined for all types of alternative care providers (limited to one consultation with registered dietician) per calendar year.	Services of Licensed Chiropractors, Licensed Massage Therapists, Registered Acupuncturists & Registered Dieticians; and office visits to Licensed Naturopaths: $15 co-pay per visit, up to 15 visits combined for all types of alternative care providers per calendar year. No deductible.
Durable Medical Equipment	Rental covered at 80% after deductible when prescribed by a physician (up to the purchase price of rental).	Covered at 80%.	Covered at 80%. After deductible.
Hearing Aids	Adults: 50% of eligible expenses covered after deductible, up to a $1000 maximum benefit during a 36-month period. Eligible Children: 80% of eligible expenses after deductible, one per hearing-impaired ear during a 36-month period.	Adults: 50% of eligible expenses covered up to a $1000 maximum benefit during a 36-month period. Eligible Children: 80% of eligible expenses with no copay, one per hearing-impaired ear during a 36-month period.	Adults: 50% of eligible expenses covered after deductible up to a $1000 maximum benefit during a 36-month period. Eligible Children: 80% of eligible expenses with no copay, one per hearing-impaired ear during a 36-month period.

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Hearing Analysis	80% after deductible if prescribed by a physician when medically necessary.	Routine hearing exams covered in full after $20 co-payment for children under age 19 once every 24 months.	Routine hearing exams covered in full after $15 co-pay for children under age 19 once every 24 months.
Home Health Care	Covered in full after deductible when provided by RN or registered physical therapist and prescribed by a physician.	Covered in full when preauthorized.	80% after deductible when preauthorized.
Hospice Care	Covered in full after deductible.	Covered in full.	80% after deductible.
Mental Health & Chemical Dependency Services, including Alcoholism	Covered the same as any other medical condition, and may be subject to deductible, coinsurance or copay and limitations. See specific service type (for example, hospital or physician services) for coverage levels. Benefits provided in accordance with state and federal requirements.		
Podiatrist	80% after deductible.	Covered in full after $20 co-pay for non-routine foot care.	Covered in full after $15 co-pay for non-routine foot care.
Prosthetic Devices (Pacemaker, artificial limb, etc.)	80% after deductible for devices replacing body functions.	80% for initial device replacing body function when obtained while you are covered by this Plan and when need first arises.	80% for initial device replacing body function when obtained while you are covered by this Plan and when need first arises. After deductible.
Tobacco Cessation Treatment	Eligible expenses covered at 100% for members age 15 or older participating in a tobacco cessation program. Eligible for participation in the PacificSource Quit for Life tobacco cessation program. No deductible required.		
Pharmacy			
The City complies with the Affordable Care Act as it applies to 100% coverage of preventative drugs outlined in the Act.			
Prescription Drugs	<u>Retail</u> – Deductible applies. No claim form required. Tier 1: $10 co-pay Tier 2: 20% co-pay Tier 3: 25% co-pay	<u>Retail</u> - No claim form required: Tier 1: 50% co-pay Tier 2: 50% co-pay Tier 3: $20 or 50% co-pay, whichever is greater	<u>Retail</u> - No deductible and no claim form required. Tier 1: 50% co-pay Tier 2: 50% co-pay Tier 3: $40 or 50% co-pay, whichever is greater
	<u>Mail Order - CVS/Caremark</u> No deductible and no claim form required. Up to 90 day supply. Tier 1: $10 co-pay Tier 2: $20 co-pay Tier 3: $25 co-pay or 25%, whichever is greater (with $60 cap)	<u>Mail-order - CVS/Caremark</u> No claim form required. Up to 90 day supply. Tier 1: $20 co-pay Tier 2: $20 co-pay Tier 3: $30 co-pay or 25%, whichever is greater (with $60 cap)	<u>Mail Order - CVS/Caremark</u> No deductible and no claim form required. Up to 90 day supply. Tier 1: $15 co-pay Tier 2: $35 co-pay Tier 3: $70 co-pay

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Vision			
Eye Exams	80% with no deductible once every 12 months.	Medical Plan - Children under age 19: Covered in full after $20 co-payment once every 24 months. Coordinates with vision benefit. Vision Plan - All: 80% with no deductible once every 12 months.	Medical Plan - Children under age 19: Covered in full after $15 co-payment once every 24 months. Coordinates with vision benefit. Vision Plan - All: 80% with no deductible once every 12 months.
Prescription Frames, Lenses and Contacts	Adults: $300 maximum every 24 months. Children under the age of 19: Prescription frames and lenses **OR** contacts covered at 100% 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)		
Dental* - Administered by Delta Dental, a Moda Health affiliated company. *The City's dental plan utilizes participating dentists who have contracts with Delta Dental. Benefit levels for non-participating dental providers are based on the prevailing fee level for covered services.			
Delta Dental Service Area	The Delta Dental Premier Network includes all counties in Oregon. Members living outside of Oregon can receive in-network benefits from a Premier provider through the Delta Dental Nationwide Network.		
Calendar Year Dental Deductible	$50 per person; $150 maximum per family. All benefits paid after the deductible is met unless otherwise noted.		
Annual Benefit Maximum	First calendar year of coverage: $250*. Each succeeding calendar year: $1,600*. *Essential dental benefits for members under the age of 19 will not be subject to the annual dental maximum. See the Employee Benefits Handbook for details.		
Preventive Dental Care-Exams, Bite-Wing X-Rays, Fluoride, and Routine Cleaning	100% no deductible.		
Fillings, Restorative Crowns, Denture Repairs	80% after $50 deductible.		
Initial and Replacement Dentures and Bridgework	50% after $50 deductible. Covered only if previous denture or bridgework is more than five years old, and teeth were removed while the covered person was eligible for coverage under this plan.		
Implants	50% after deductible, subject to the annual benefit maximum. Implant placement and removal once per lifetime per tooth space.		
Orthodontia	50% with no deductible. $2,000 lifetime maximum per covered person.		

City Hybrid Plan Additional Information

**Disallowed charges do not apply to the annual deductible or to the out-of-pocket maximum. Expenses applied toward the annual deductible do not apply to the out-of-pocket maximum. The City Hybrid Plan will be administered under the same terms and conditions as the City Managed Care Plan.