Eugene Central Services
Risk Services

EPEA-Represented

Regular Part-Time Employee Payroll Reductions

Effective July 1, 2019

1. The payroll deduction for part-time employees electing employee-only coverage is 5% of the premium up to a $52.00 monthly maximum.
2. Part-time employees opting for dependent coverage pay a percentage of the premium pro-rated to their standard hours in the payroll system, per the table below.
3. Payroll reductions are taken on a pre-tax basis, except when covering Domestic Partners who are not tax dependents.
4. Employees may opt-out of coverage with proof of other health insurance.

HEALTH PLAN RATES

EPEA-Represented Employee Monthly Med/Dent/Vis Rates:

	City Health Plan	City Managed Care Plan
Individual	$912.28 /mo.	$746.08 /mo.
Two Party	$1,731.17 /mo.	$1,515.97 /mo.
Family	$2,413.45 /mo.	$2,212.56 /mo.

EMPLOYEE PAYROLL DEDUCTIONS

EPEA-Represented Payroll deductions Per Pay Period:

Work Schedule		City Health Plan	City Managed Care Plan
20 - 23.9 hours/week (50% of Premium):			
	Individual	$22.81 /pay period	$18.66 /pay period
	Two Party	$432.79 /pay period	$378.99 /pay period
	Family	$603.36 /pay period	$553.14 /pay period
24 - 31.9 hours/week (25% of Premium):			
	Individual	$22.81 /pay period	$18.66 /pay period
	Two Party	$216.40 /pay period	$189.50 /pay period
	Family	$301.68 /pay period	$276.57 /pay period
32 - 40 hours/week (same as full-time):			
	Individual	$22.81 /pay period	$18.66 /pay period
	Two Party	$43.28 /pay period	$37.90 /pay period
	Family	$60.34 /pay period	$55.32 /pay period

If you have any questions please contact the Benefits staff in Risk Services at 682-5062.

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

Effective July 1, 2019

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.

For further information please review your handbook at www.eugene-or.gov/EmployeeBenefits, or contact our administrators, PacificSource Health Plans for medical, pharmacy or vision benefits or Delta Dental for dental benefits.

EPEA-Represented BENEFITS	City Health Plan In-Network Benefit	City Managed Care Plan In-Network Benefit
General Information		
Payroll Deduction	EPEA-Represented full-time employees: Individual $45.62 per month Two-Party $86.56 per month Family $120.68 per month Employees may Opt-Out of health insurance with proof of other coverage.	EPEA-Represented full-time employees: Individual $37.31 per month Two-Party $75.80 per month Family $110.63 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: ▪ In-Network provider: 80% of discounted rates; ▪ Non-Network provider: 50% of reasonable and customary charges.	Most Non-Network provider benefits are 50% of reasonable and customary charges after co-pay.
Service Area	Worldwide.	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 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	Medical: $130 per person; $390 maximum per family. Dental: $30 per person; $100 maximum per family. All benefits paid after the deductible is met unless otherwise noted.	Medical: No deductible for medical coverage. Dental: $30 per person; $100 maximum per family. All benefits paid after the deductible is met unless otherwise noted.
Out of Pocket Medical Maximum	$950 per person each calendar year, in addition to the deductible, for covered Medical and Prescription services. Once this limit has been met, eligible charges are covered in full for remainder of calendar year.	$1,100 per person each calendar year for covered expenses. Once this limit has been met, eligible charges are covered in full for remainder of calendar year.

EPEA-Represented BENEFITS	City Health Plan In-Network Benefit	City Managed Care Plan In-Network Benefit
Out of Pocket Rx Maximum	Combined Prescription and Medical Out of Pocket Maximum (see above). Once this limit has been met, eligible charges are covered in full for remainder of calendar year.	$1,350 per person each calendar year. Once this limit has been met, eligible prescriptions are covered in full for remainder of calendar year.
Annual Dental Benefit Maximums	First calendar year of coverage: $300*. Each succeeding calendar year: $1,300*. *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)** **Risk Services Employee Benefits Program: 541.682.5062**	
Medical, Vision and Pharmacy Benefits – Administered by PacificSource Health Plans		
Physician Services		
Surgery/Delivery		
Inpatient	80% after deductible.	Covered in full.
Outpatient	100% no deductible.	Surgery covered in full. $15 office visit co-payment if performed in physician's office.
Office Visits	80% after deductible; 80% no deductible for treatment of accidental injury.	Covered in full after $15 co-payment per visit.
Hospital Visits	80% after deductible.	Covered in full.
Allergy Injections	80% after deductible.	Covered in full.
Hospital Services		
Semi-private Room and Board	80% after deductible. *Subject to compliance with utilization review.*	Paid in full after $60 co-payment per day ($300 maximum per stay).
Emergency Care		
Within Service Area	80% after deductible for treatment of illness; 80% with no deductible for treatment of accidental injury.	$60 co-payment per visit; waived if admitted.
Outside of Service Area	80% after deductible for treatment of illness; 80% with no deductible for treatment of accidental injury.	$60 co-payment per visit; waived if admitted.
Emergency Transportation	100%, no deductible.	$50 per trip; waived if admitted. Air ambulance covered when preauthorized.
Outpatient Services		
CT Scans and MRI	80% after deductible for illness; 80% no deductible for treatment of accidental injury.	Covered in full.
X-Ray, Lab Tests and Radiation Therapy	80% after deductible for illness; 80% no deductible for treatment of accidental injury.	Covered in full.
Rehabilitation (Physical Therapy)	80% after deductible if prescribed by physician.	Covered in full after $15 co-pay per session; limited to 30 sessions/year if prescribed by physician, (combined with Occupational & Speech Therapy). May require pre-authorization.

EPEA-Represented BENEFITS	City Health Plan In-Network Benefit	City Managed Care Plan In-Network Benefit
Occupational and Speech Therapy	80% after deductible for certain medical conditions if prescribed by physician.	Covered in full after $15 co-pay per. Limited to 30 sessions/year (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 $60 co-payment per day ($300 maximum per stay).
Physician Hospital Services including Prenatal, Delivery and Postnatal Care of Mother and Child	80% after deductible.	Covered in full after $25 co-payment per pregnancy.
Preventive and Well-Care Services		
Periodic Physical Exams	Covered at 80% no deductible.	Covered in full after $15 co-payment per visit.
Well-Baby/Child Care	Covered at 80% during first 24 months; no deductible.	Covered in full after $15 co-payment per visit (subject to schedule).
Immunizations	Covered at 80% for adults and children; no deductible. Children under age 2 covered under Well-baby/Child Care.	Covered in full.
Cancer Screenings and Gynecological Exams: including Colonoscopy, Mammography, Breast, Pap and Pelvic Exams	Covered at 80%; no deductible. Subject to schedule of eligibility	Covered in full after $15 co-pay. (Routine mammograms covered in full.) Subject to schedule of eligibility.
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 and Registered Dieticians; and office visits to Licensed Naturopaths: $15 co-pay per visit, up to 12 visits combined for all types of alternative care providers (limited to one consultation with registered dietician) per calendar year.
Durable Medical Equipment	Rental covered at 80% after deductible when prescribed by a physician (up to the purchase price of rental).	Covered at 80%.

EPEA-Represented BENEFITS	City Health Plan In-Network Benefit	City Managed Care Plan In-Network Benefit
Hearing Aids	Adults: 50% of eligible expenses covered after deductible, up to a $500 maximum benefit during a 36-month period. Dependent 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 $500 maximum benefit during a 36-month period. Dependent Children: 80% of eligible expenses with no copay, one per hearing-impaired ear during a 36-month period.
Hearing Analysis	Covered at 80% after deductible if prescribed by a physician when medically necessary.	Routine hearing exams covered in full after $15 co-payment 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.
Hospice Care	Covered in full after deductible.	Covered in full when preauthorized.
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 $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.
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	Retail – Deductible applies. Pay discounted price in full at pharmacy, and then submit claim form for reimbursement. Tier 1: $10 co-pay Others: 20% co-pay	Retail - No claim form required. Tier 1: 50% co-pay or $10* Tier 2: 50% co-pay or $25* Tier 3: 50% co-pay or $40* *whichever is greater
	Mail Order - CVS/Caremark No deductible; no claim form required. Up to 90 day supply. Tier 1: $10 co-pay Tier 2: $25 co-pay Tier 3: $25 co-pay or 25%, whichever is greater (with $65 cap)	Mail-order - CVS/Caremark: No claim form required. Up to 90 day supply. Tier 1: $15 co-pay Tier 2: $25 co-pay Tier 3: $50 co-pay

EPEA-Represented BENEFITS	City Health Plan In-Network Benefit	City Managed Care Plan In-Network Benefit
Vision		
Eye Exams	80% with no deductible once every 12 months, with benefit cap of $75 for members age 19 and older.	Medical Plan - Children under age 19: Covered in full after $15 co-payment once every 24 months. Coordinates with vision benefit. Vision Plan – All: Covered at 80% with no deductible once every 12 months, with benefit cap of $75 for members age 19 and older.
Prescription Lenses	Adults: Lenses and frames **or** cosmetic contacts covered once every 24 months. Frames $60 Single lens $25 per lens Bifocals $40 per lens Cosmetic Contacts $90 (both lenses) $75 per lens for contacts required after cataract surgery or if vision cannot be corrected to 20/70 without such lenses. Covered once every 24 months. Children under the age of 19: Prescription frames and lenses **OR** contacts covered at 100% once every 12 months. Contact 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 Delta Dental Nationwide Association.	
Dental Deductible	$30 per person; $100 maximum per family. All benefits paid after the deductible is met unless otherwise noted.	
Maximums	First calendar year of coverage: $300*. Each succeeding calendar year: $1,300*. *Does not apply to essential dental benefits for members under age 19. See the Employee Benefits Handbook for details.	
Preventive Dental Care: Exams, Fluoride Bite-Wing X-Rays, and Routine Cleaning	100% no deductible.	
Fillings, Restorative Crowns, Denture Repairs	80% after $30 deductible.	
Initial and Replacement Dentures and Bridgework	50% after $30 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.	
Orthodontia	50% with no deductible. $2,000 lifetime maximum per covered person.	