Eugene Central Services
Risk Services

Non-Represented

Regular Part-Time and Limited Duration Employee Payroll Reductions

Effective January 1, 2019

1. The payroll deduction for full-time Non-Represented limited duration employees, with or without dependent coverage, is 8% of the premium for the City Health Plan and the City Managed Care Plan, and 4% of the premium for the City Hybrid Plan.
2. The payroll deduction for part-time regular or limited duration employees electing employee-only coverage is 8% of the premium for the City Health Plan and the City Managed Care Plan, and 4% of the premium for the City Hybrid Plan.
3. Non-Represented part-time regular or limited duration employees opting for dependent coverage pay the cost as a payroll deduction, pro-rated to their standard hours in the payroll system, per the table below.
4. Payroll deductions are taken on a pre-tax basis, except when covering Domestic Partners who are not tax dependents.
5. Employees may opt-out of coverage with proof of other health insurance.

HEALTH PLAN RATES

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

	City Health Plan	City Managed Care Plan	City Hybrid Plan
Individual	$884.80 /mo.	$722.85 /mo.	$618.95 /mo.
Two Party	$1,676.72 /mo.	$1,466.19 /mo.	$1,252.00 /mo.
Family	$2,335.96 /mo.	$2,137.92 /mo.	$1,825.81 /mo.

EMPLOYEE PAYROLL DEDUCTIONS

Non-Represented Payroll deductions Per Pay Period:

Work Schedule	City Health Plan	City Managed Care Plan	City Hybrid Plan
20 - 23.9 hours/week (50% of premium):			
Individual	$35.40 /pay period	$28.92 /pay period	$12.38 /pay period
Two Party	$419.18 /pay period	$366.55 /pay period	$313.00 /pay period
Family	$583.99 /pay period	$534.48 /pay period	$456.45 /pay period
24 - 31.9 hours/week (25% of premium):			
Individual	$35.40 /pay period	$28.92 /pay period	$12.38 /pay period
Two Party	$209.59 /pay period	$183.27 /pay period	$156.50 /pay period
Family	$292.00 /pay period	$267.24 /pay period	$228.23 /pay period
32 - 40 hours/week (Same as full-time):			
Individual	$35.40 /pay period	$28.92 /pay period	$12.38 /pay period
Two Party	$67.07 /pay period	$58.65 /pay period	$25.04 /pay period
Family	$93.44 /pay period	$85.52 /pay period	$36.52 /pay period

If you have questions, contact Benefits Staff in Risk Services at 682-5062.

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

Effective January 1, 2019

Medical/Vision/Pharmacy coverage is administered by PacificSource Health Plans
Dental coverage is administered by Delta Dental, a Moda Health affiliated company
City of Eugene Employee Benefits Website: www.eugene-or.gov/employeebenefits

BENEFITS – NON-REP	City Health Plan In-Network Benefit	City Managed Care Plan In-Network Benefit	City Hybrid Plan** In-Network Benefit
Note: Benefits described below for the health plan options assume plan members receive in-network services preauthorized by their City Managed Care Plan or City Hybrid Plan or through the City Health Plan.			
General Information			
Payroll Deduction	Individual: $70.79 per month Two-Party: $134.14 per month Family: $186.88 per month Employees may Opt-Out of health insurance with proof of other coverage.	Individual: $57.83 per month Two-Party: $117.30 per month Family: $171.04 per month Employees may Opt-Out of health insurance with proof of other coverage.	Individual: $24.76 per month Two-Party: $50.08 per month Family: $73.04 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.	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.	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 for medical coverage. 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.

BENEFITS – NON-REP	City Health Plan In-Network Benefit	City Managed Care Plan In-Network Benefit	City Hybrid Plan** In-Network Benefit
Out-of-Pocket Medical Maximum	$1,000 per person each calendar year, in addition to the deductible, for covered medical services. Once this limit has been met, eligible medical charges are covered in full for remainder of calendar year.	$1,000 per person each calendar year for covered medical services. Once this limit has been met, eligible medical charges are covered in full for remainder of calendar year.	$1,000 per person each calendar year for covered medical expenses. Once this limit has been met, eligible charges are covered in full for remainder of calendar year.
Out-of-Pocket Rx Maximum	Retail: $1,000 per person per calendar year for retail pharmacy. Once this limit has been met, eligible retail prescriptions will be covered in full. Mail-order prescriptions do not have an out of pocket maximum.	Retail: $1,300 per person per calendar year for retail pharmacy. Once this limit has been met, eligible retail prescriptions will be covered in full. Mail-order prescriptions do not have an out of pocket maximum.	Retail: $1,300 per person per calendar year for retail pharmacy. Once this limit has been met, eligible retail prescriptions will be covered in full. Mail-order prescriptions do not have an out of pocket maximum.
Annual Dental Benefit Maximum	$1,500* per person per calendar year, including the first calendar year of coverage. *Does not apply to essential dental benefits for members under age 16. See the Employee Benefits Handbook for details.		
Claims Filing	Claim forms may be submitted by either the patient or the provider.	No claim forms needed.	Claim forms may be submitted by either the patient or the provider.
For more information contact:	PacificSource Health Plans – 541.225.1950 or 888.532.5332 (medical/vision/pharmacy) Delta Dental Plan of Oregon - Portland Office: 888.217.2365 (dental) Risk Services Employee Benefits Program: 541.682.5062		
This comparison of benefits summarizes the general benefits under each plan. It does not provide a full description of benefits. For further information please contact PacificSource for your medical, pharmacy or vision benefits, or Delta Dental for your dental benefits.			
Medical, Vision and Pharmacy Benefits – Administered by PacificSource Health Plans			
Physician Services			
Surgery/Delivery			
Inpatient	80% after deductible.	Covered in full.	80% after deductible.
Outpatient	100% no deductible for physician services. 80% after deductible for outpatient facility charges.	Surgery covered in full. $15 office visit co-pay if performed in physician's office. Outpatient facility charges covered in full.	$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 $15 co-pay per visit.	Covered in full after $15 co-pay per visit.
Hospital Visits	80% after deductible.	Covered in full.	80% after deductible.
Allergy Injections	80% after deductible.	Covered in full.	80% after deductible.
Hospital Services			

BENEFITS – NON-REP	City Health Plan In-Network Benefit	City Managed Care Plan In-Network Benefit	City Hybrid Plan** In-Network Benefit
Semi-private Room and Board	80% after deductible. *Subject to compliance with utilization review.*	Paid in full after $100 co-pay per day ($500 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-pay per visit; waived if admitted.	$100 co-pay 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.	$100 co-pay per visit; waived if admitted.	$100 co-pay per visit; waived if admitted.
Emergency Transportation	80% after 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.	Covered in full.	80% after deductible
X-Ray, Lab Tests and Radiation Therapy	80% after deductible for illness; 80% no deductible for treatment of accidental injury.	Covered in full.	80% after deductible
Rehabilitation - Physical Therapy	80% after deductible if prescribed by physician.	Covered in full after $15 co-pay per session; limited to 30 sessions/yr. (combined with Occupational & Speech Therapy). Must be preauthorized.	Covered in full after $15 co-pay. No deductible. Limited to 30 sessions/yr. (combined with Occupational & Speech Therapy). Must be preauthorized.
Occupational and Speech Therapy	80% after deductible for certain medical conditions if prescribed by physician.	Covered in full after $15 co-pay per session; limited to 30 sessions/yr. (combined with Physical Therapy). Must be preauthorized.	Covered in full after $15 co-pay per session; limited to 30 sessions/yr (combined with Physical Therapy). Must be preauthorized. No deductible
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 $100 co-pay per day ($500 maximum per stay).	$100 co-pay then 80% (co-pay limited to 5 days)

BENEFITS – NON-REP	City Health Plan In-Network Benefit	City Managed Care Plan In-Network Benefit	City Hybrid Plan** In-Network Benefit
Physician Hospital Services including Prenatal, Delivery and Postnatal Care of Mother and Child	80% after deductible.	Covered in full after $25 co-pay per pregnancy.	Covered in full after $15 co-pay per visit.
Preventive and Well-Care Services			
Periodic Physical Exams	Covered at 100% no deductible.	Covered in full.	Covered in full. No deductible
Well-Baby/Child Care	Covered at 100% during first 24 months, no deductible.	Covered in full (subject to schedule).	Covered in full. No deductible
Immunizations	Covered at 100% for adults and children; no deductible. Children under age 2 covered under Well-Baby/Child Care	Covered in full.	Covered in full. No deductible
Cancer Screenings and Gynecological Exams, including Colonoscopy, Mammography, Breast, Pap and Pelvic Exams	Covered at 100%, no deductible. Subject to schedule of eligibility.	Covered in full. (Routine mammograms covered in full.) Subject to schedule of eligibility.	Covered in full. (Routine mammograms 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, Licensed Massage Therapists, and Registered Dietitians: 80% after deductible, limited to 10 visits combined for these service providers 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.	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 48-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 48-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 48-month period.

BENEFITS – NON-REP	City Health Plan In-Network Benefit	City Managed Care Plan In-Network Benefit	City Hybrid Plan** In-Network Benefit
Hearing Analysis	80% after deductible if prescribed by a physician when medically necessary.	Routine hearing exams covered in full after $15 co-pay 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 when preauthorized.	80% after deductible 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.	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

BENEFITS – NON-REP	City Health Plan In-Network Benefit	City Managed Care Plan In-Network Benefit	City Hybrid Plan** In-Network Benefit
Prescription Drugs	Retail No deductible and no claim form required. Show PacificSource Wallet ID Card at retail pharmacy to receive benefit. Co-pay: Generic: 10% or $10 co-pay* Preferred: 20% or $15 co-pay* Non-Preferred: 25% or $25 co-pay* (*Whichever is greater)	Retail No deductible and no claim form required. Show PacificSource Wallet ID Card at retail pharmacy to receive benefit. Receive up to 34-day supply (30-day supply for self-injectables) Co-pay: Generic: 50% co-pay Preferred: 50% co-pay Non-Preferred: $40 or 50% co-pay* (*Whichever is greater)	Retail No deductible and no claim form required. Show PacificSource Wallet ID Card at retail pharmacy to receive benefit. Receive up to 34-day supply (30-day supply for self-injectables) Co-pay: Generic: 50% co-pay Preferred: 50% co-pay Non-Preferred: $40 or 50% co-pay* (*Whichever is greater)
	Mail Order (CVS Caremark) No deductible and no claim form required. Receive up to 90-day supply (30-day supply for self-injectables) Co-pay: Generic: 10% or $10 co-pay* Preferred: 20% or $15 co-pay* Non-Preferred: 25% or $25 co-pay* (*Whichever is greater)	Mail Order (CVS Caremark) No deductible and no claim form required. Receive up to 90-day supply (30-day supply for self-injectables) Co-pay: Generic: $15 co-pay Preferred: $35 co-pay Non-Preferred: $70 co-pay	Mail Order (CVS Caremark) No deductible and no claim form required. Receive up to 90-day supply (30-day supply for self-injectables) Co-pay: Generic: $15 co-pay Preferred: $35 co-pay Non-Preferred: $70 co-pay
Vision			
Eye Exams	80% with no deductible once every 12 months.	Medical Plan - Children under age 19: Covered in full after $15 co-pay once every 24 months. Coordinates with vision plan. 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.

BENEFITS – NON-REP	City Health Plan In-Network Benefit	City Managed Care Plan In-Network Benefit	City Hybrid Plan** In-Network Benefit
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.		
Calendar Year Dental Deductible	$50 per person; $150 maximum per family. All benefits paid after the deductible is met unless otherwise noted.		
Annual Benefit Maximums	$1,500* per person per calendar year, including the first calendar year of coverage. *Essential dental benefits for members under the age of 16 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 every 6 months.		
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 $50 deductible. 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

**Fixed dollar co-pays, prescription drug co-pays, and 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.