COMPARISON OF BENEFITS*
FOR CITY OF EUGENE
IAFF-BC-REPRESENTED EMPLOYEES

Effective July 1, 2021

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 www.eugene-or.gov/EmployeeBenefits, or contact our administrators, PacificSource Health Plans for medical, pharmacy or vision benefits or Delta Dental for dental benefits.

BENEFITS – IAFF-BC	City Health Plan In-Network Benefit	City Managed Care Plan In-Network Benefit
Payroll Deduction	Individual: $46.00 per month Two-Party: $87.17 per month Family: $121.47 per month Employees may Opt-Out of health insurance with proof of other coverage.	Individual: $37.54 per month Two-Party: $76.15 per month Family: $111.06 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.
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 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 for medical coverage. Dental: $50 per person; $150 maximum per family.
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.
Out-of-Pocket Rx Maximum	$1,000 per person per calendar year. Once this limit has been met, eligible prescriptions will be covered in full.	$1,300 per person per calendar year. Once this limit has been met, eligible prescriptions will be covered in full.

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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 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		
Physician Services		
Surgery/Delivery		
Inpatient	80% after deductible.	Covered in full.
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.
Office Visits	80% after deductible; 80% no deductible for treatment of accidental injury.	Covered in full after $15 co-pay per visit.
Teladoc - Medical and Behavioral Telehealth Physician Consults	Currently covered at 100% with 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.
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 $100 co-pay per day ($500 maximum per stay).
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.
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.
Emergency Transportation	80% after 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.

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Outpatient Rehabilitation: Physical Therapy, Occupational & Speech Therapy, and Pulmonary Rehabilitation	80% after deductible. Limited to 30 sessions per calendar year for all services combined. Additional visits may be authorized by PacificSource. No limit on speech therapy services for appropriate and medically necessary treatment of Autism Spectrum Disorder.	Covered in full after $15 co-pay per session. Limited to 30 sessions per calendar year for all services combined. Additional visits may be authorized by PacificSource. No limit on speech therapy services for appropriate and medically necessary treatment of Autism Spectrum Disorder.
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).
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.
Preventive and Well-Care Services		
Periodic Physical Exams	Covered at 80% no deductible.	Covered in full after $15 co-pay per visit.
Well-Baby/Child Care	Covered at 80%, no deductible (subject to schedule recommended by Health Resources & Services Administration).	Covered in full after $15 co-pay per visit (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.
Immunizations	COVID-19 Vaccination covered at 100%, no deductible. Others covered at 80% for adults and children; no deductible. Children under age 3 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 & 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%.

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Hearing Aids	Adults: 50% of eligible expenses covered after deductible, up to a $500 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 $500 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.
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 when performed by PCP.
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 when preauthorized by a PCP.
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	<u>Retail</u> No deductible and no claim form required. Tier 1: 10% or $10 co-pay* Tier 2: 20% or $15 co-pay* Tier 3: 25% or $25 co-pay* (*Whichever is greater)	<u>Retail</u> No deductible and no claim form required. Receive up to 34-day supply (30-day supply for self-injectables) 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. Receive up to 90-day supply (30-day supply for self-injectables) Tier 1: 10% or $10 co-pay* Tier 2: 20% or $15 co-pay* Tier 3: 25% or $25 co-pay* (*Whichever is greater)	<u>Mail Order - CVS Caremark</u> No deductible and no claim form required. Receive up to 90-day supply (30-day supply for self-injectables) 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 $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: $150 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 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 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 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.	