

Oregon Teamster Employers Trust: Self-Funded GW Plan Coverage Period: On or after 01/01/2015

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage for: Family | Plan Type: PPO



This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document by calling 503-460-5212 local or 1-877-396-4612 toll free.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	\$150 individual/ \$450 family	You must pay all the costs up to the deductible amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the deductible starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the deductible .
Are there other deductibles for specific services?	Yes, \$150 for emergency room and \$3,500 for bariatric surgery. There are no other specific deductibles .	You don't have to meet deductibles for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an <u>out-of-pocket limit</u> on my expenses?	Yes, \$1,150 per family for medical and \$750 per family for prescription drugs.	The out-of-pocket limit is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the <u>out-of-pocket limit</u> ?	Premiums, balance-billed charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit .
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes <i>specific</i> coverage limits, such as limits on the number of office visits.
Does this plan use a <u>network of providers</u> ?	Yes. For a list of preferred providers , see www.or.regence.com or call (503) 220-6100 or 1-800-452-8812.	If you use an in-network doctor or other health care provider , this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network provider for some services. Plans use the term in-network, preferred , or participating for providers in their network . See the chart starting on page 2 for how this plan pays different kinds of providers .
Do I need a referral to see a <u>specialist</u> ?	No.	You can see the specialist you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 4. See your policy or plan document for additional information about excluded services .

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- **Copayments** are fixed dollar amounts (for example, \$15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is \$1,000, your **coinsurance** payment of 20% would be \$200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges \$1,500 for an overnight stay and the **allowed amount** is \$1,000, you may have to pay the \$500 difference. (This is called **balance billing**.)
- This plan may encourage you to use **PPO providers** by charging you lower **deductibles, copayments and coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you visit a health care <u>provider's</u> office or clinic	Primary care visit to treat an injury or illness	10% coinsurance	20% coinsurance	none
	Specialist visit	10% coinsurance	20% coinsurance	none
	Other practitioner office visit	10% coinsurance for Chiropractor	20% coinsurance for Chiropractor	Limited to \$12 per visit and 26 visits in a six month period for Chiropractor.
If you have a test	Preventive care/screening/immunization	No charge	20% coinsurance	none
	Diagnostic test (x-ray, blood work)	10% coinsurance	20% coinsurance	none
	Imaging (CT/PET scans, MRIs)	10% coinsurance	20% coinsurance	Some services require preauthorization.

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Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition	Generic drugs	10% coinsurance	Not Covered	31 day supply \$5 minimum for retail, \$10 for 32-60 day supply, and \$15 for 61-90 day supply. \$12.50 minimum for mail. \$750 maximum copay per family.
	Preferred brand drugs	15% coinsurance	Not Covered	31 day supply \$15 minimum for retail, \$30 for 32-60 day supply, and \$45 for 61-90 day supply. \$37.50 minimum for mail. \$750 maximum copay per family.
More information about prescription drug coverage is available at www.express-scripts.com .	Non-preferred brand drugs	25% coinsurance	Not Covered	31 day supply \$25 minimum for retail, \$50 for 32-60 day supply, and \$75 for 61-90 day supply. \$62.50 minimum for mail. \$750 maximum copay per family.
	Specialty drugs	Same as above	Same as above	Requires preauthorization.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance	20% coinsurance	_____ none _____
	Physician/surgeon fees	10% coinsurance	20% coinsurance	_____ none _____
If you need immediate medical attention	Emergency room services	10% coinsurance	10% coinsurance	Deductible waived if admitted.
	Emergency medical transportation	15% coinsurance	15% coinsurance	_____ none _____
	Urgent care	10% coinsurance	20% coinsurance	_____ none _____
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance	20% coinsurance	_____ none _____
	Physician/surgeon fee	10% coinsurance	20% coinsurance	_____ none _____
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	10% coinsurance	20% coinsurance	_____ none _____
	Mental/Behavioral health inpatient services	10% coinsurance	20% coinsurance	_____ none _____
	Substance use disorder outpatient services	10% coinsurance	20% coinsurance	_____ none _____
	Substance use disorder inpatient services	10% coinsurance	20% coinsurance	_____ none _____
If you are pregnant	Prenatal and postnatal care	10% coinsurance	20% coinsurance	Pregnancy expenses of dependent children are excluded.
	Delivery and all inpatient services	10% coinsurance	20% coinsurance	

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Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Home health care	10% coinsurance	20% coinsurance	Limited to 180 visits per year, 2 visits per day maximum.
	Rehabilitation services	10% coinsurance	20% coinsurance	Limited to 1 session of a given type per day and 30 visits per year (60 visits per year for head and spinal injury) for outpatient.
	Habilitation services	10% coinsurance	20% coinsurance	Limited to 90 days per year
	Skilled nursing care	10% coinsurance	20% coinsurance	_____none_____
	Durable medical equipment	10% coinsurance	20% coinsurance	Deductible waived.
	Hospice service	10% coinsurance	20% coinsurance	
If your child needs dental or eye care	Eye exam	Not covered	Not covered	Covered under separate vision plan.
	Glasses	Not covered	Not covered	
	Dental check-up	Not covered	Not covered	Covered under separate dental benefit

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Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Cosmetic surgery
- Hearing aids
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside of the U.S.
- Private-duty nursing
- Routine eye care
- Routine foot care
- Weight loss programs

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Acupuncture
- Bariatric surgery
- Chiropractic care
- Dental care (Adult)

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About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.



This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby (normal delivery)

- Amount owed to providers: \$7,540
- Plan pays \$6,530
- Patient pays \$1,010

Sample care costs:

Hospital charges (mother)	\$2,700
Routine obstetric care	\$2,100
Hospital charges (baby)	\$900
Anesthesia	\$900
Laboratory tests	\$500
Prescriptions	\$200
Radiology	\$200
Vaccines, other preventative	\$40
Total	\$7,540

Patient pays:

Deductibles	\$150
Copays	\$0
Coinsurance	\$710
Limits or exclusions	\$150
Total	\$1,010

Managing type 2 diabetes (routine maintenance of a well-controlled condition)

- Amount owed to providers: \$5,400
- Plan pays \$4,660
- Patient pays \$740

Sample care costs:

Prescriptions	\$2,900
Medical Equipment and Supplies	\$1,300
Office Visits and Procedures	\$700
Education	\$300
Laboratory tests	\$100
Vaccines, other preventative	\$100
Total	\$5,400

Patient pays:

Deductibles	\$150
Copays	\$0
Coinsurance	\$510
Limits or exclusions	\$80
Total	\$740

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Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✗ No. Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✗ No. Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ Yes. When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ Yes. An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

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