Teamsters 206 Employers Trust

February 1, 2020 - **Comparison** Summary of Welfare Plan Benefits - **Medical Plan A**

Benefit/Plan Feature	Trust Plan		Kaiser Permanente	Providence Health Plan
Choice of Physician and Hospital (Non-Emergency Care)	No restrictions, except that treatment received from Preferred Providers reduce employee out-of-pocket costs. **Note:** When you access care from a non-preferred provider, benefits are paid based on Usual, Customary and Reasonable (UCR) charges. Therefore, you could be subject to additional out-of-pocket costs for any amount the non-preferred provider charges over UCR. Cigna is the Trust's preferred provider network. See www.cignasharedadministration.com or call 1-800-768-4695 for a list of Cigna's participating providers.		Must receive services from the NW Permanente Medical group physicians and use Kaiser Hospitals in Portland including: Kaiser Sunnyside Medical Center, Kaiser Westside Medical Center, OHSU Doernbecher Children's Hospital (for children 17 and younger), Salem Hospital, Legacy Salmon Creek Medical Center in Vancouver.	Must receive services from a Providence Health Plan participating provider except for qualified emergency care or urgent care when an in-network provider is not available. Find in-network providers and facilities through the online provider directory, www.ProvidenceHealthPlan.com , or call 503-574-7500 or 1-800-878-4445 for a list of participating providers.
Service Area	Preferred Providers throughout the United States. The service area for non-preferred providers is unlimited.		Benton, Clackamas, Columbia, Linn, Polk, Marion, Multnomah, Washington, Lane, Hood River, Yamhill Counties in Oregon. Cowlitz, Clark, Lewis, and Wahkiakum Counties in Washington. **Note:** Not all zip codes in each county are included. For further information, contact Kaiser Permanente at 503-813-2000 or 1-800-813-2000.	**In Oregon:** All zip codes in Oregon. **In Washington:** All zip codes in Clark, Klickitat, and Skamania counties.
Annual Deductible				
Individual	$200		None	$250
Family	$600 (3 family members must each meet a $200 deductible)		None	$750
Annual Out-of-Pocket Maximum				
Individual	$1,200 per person in-network. $1,700 per person out-of-network (includes deductibles and medical copays – excludes prescription drug copays). Once you have reached your out-of-pocket maximum, the Plan pays 100%.		$1,250	$1,700 (after deductible)
Family			$2,500	$5,100 (after deductible)
Lifetime Maximum Benefit	None		None	None
Preventive Services	**PPO**	**Non-PPO**		
Periodic Health Exams for Adults and Children	$20 copay	Not covered	$25 copay	$20 copay (from a Primary Care Provider Only)
Well Child Care (Including Immunizations)	$20 copay (frequency according to schedule)	Not covered	Covered in full for children under 2	$20 copay (from a Primary Care Provider Only)
Annual Gynecological Exams	$20 copay	Not covered	$25 copay	$20 copay
Prostate Exams	$20 copay (frequency according to schedule)	Not covered	$25 copay	$20 copay (from a Personal Physician only) (from a Primary Care Provider Only)
Mammograms	$20 copay (frequency according to schedule)	Not covered	$20 copay	$20 copay

Benefit/Plan Feature	Trust Plan		Kaiser Permanente	Providence Health Plan
Physician/Provider Services				
Office Visits	$20 copay	Plan pays 70% after deductible	$25 copay. Includes mental health/chemical dependency.	$20 copay includes mental health/chemical dependency outpatient visits.
Specialist Visits	$20 copay	Plan pays 70% after deductible	$25 copay	$20 copay
Inpatient Hospital Visits	Plan pays 80% after deductible	Plan pays 70% after deductible	$250 per admission. Includes mental health/chemical dependency.	Plan pays 80% after deductible. Includes mental health/chemical dependency.
Surgery & Anesthesia	Plan pays 80% after deductible	Plan pays 70% after deductible	Covered in full (included in the Inpatient/outpatient cost share)	Plan pays 80% after deductible
Emergency Room Visits	Plan pays 80% after deductible	Plan pays 70% after deductible	$75 (waivered if admitted)	Plan pays 100% after $100 copay and deductible (for all Emergency services.)
Allergy Shots	Plan pays 80% after deductible	Plan pays 70% after deductible	$5 copay	Plan pays 80% after deductible
Hospital Services				
Acute Care (Room & Board and Ancillary Charges)	Plan pays 80% after deductible	Plan pays 70% after deductible	$250 copay per admission	Plan pays 80% after deductible
Rehab Care, Skilled Nursing	Plan pays 80% after deductible	Plan pays 70% after deductible	Multidisciplinary Rehab: $250 per admission; Skilled Nursing Covered in full (up to 100 days)	Plan pays 80% after deductible (limited to 30 days per calendar year for Rehab; 60 days per calendar year for Skilled nursing)
Outpatient Surgery	Plan pays 80% after deductible	Plan pays 70% after deductible	$25 copay	Plan pays 80% after deductible
Maternity				
Pre-Natal and Post-Natal Visits	$20 copay	Plan pays 70% after deductible	Covered in full	$200 copay per pregnancy
Delivery	Plan pays 80% after deductible	Plan pays 70% after deductible	Inpatient hospital copay	Included in the $200 copay
Hospital Services (Room & Board and Ancillary Charges)	Plan pays 80% after deductible	Plan pays 70% after deductible	Inpatient hospital copay	Plan pays 80% after deductible
Routine Newborn Nursery Care	Plan pays 80% after deductible	Plan pays 70% after deductible	Covered in full	Plan pays 80%
Infertility/Fertility Services	Not covered	Not covered	50% coinsurance	Not covered
	PPO	**Non-PPO**		
Emergency Services	$100 copay (Deductible does not apply, and copay is waived if you are directly admitted to the hospital)		$75 copay (Copay is waived if you are directly admitted to the hospital)	Plan pays 100% after $100 copay and deductible (for all Emergency services.)
Urgent Care Services	$50 copay	Plan pays 70% after deductible	$20 copay	$20 copay (services, such as lab and x-ray, will be charged separately and are covered at 80% after deductible)
Ambulance	Plan pays 80% after deductible	Plan pays 70% after deductible	$75 copay	Plan pays 80% after deductible

Benefit/Plan Feature	Trust Plan		Kaiser Permanente	Providence Health Plan
Other Covered Services	**PPO**	**Non-PPO**		
X-Ray & Lab Services	Plan pays 80% after deductible	Plan pays 70% after deductible	$20 copay per visit	Plan pays 80% after deductible
Durable Medical Equipment	Plan pays 80% after deductible	Plan pays 70% after deductible	20% coinsurance	Plan pays 80% after deductible; Deductible does not apply to diabetic supplies.
Outpatient Rehabilitation	Plan pays 80% after deductible	Plan pays 70% after deductible	$25 copay	Plan pays 80% after deductible (up to 30 visits per calendar year)
Home Health Care	Plan pays 80% after deductible	Plan pays 70% after deductible	Covered in full (up to 130 visits per calendar year)	Plan pays 80% after deductible
Hospice	Covered in full	Covered in full	Covered in full	Covered in full
Mental Health				
Inpatient	Covered under hospital inpatient	Covered under hospital inpatient	Covered under hospital inpatient	Covered under hospital inpatient
Chemical Dependency				
Inpatient	Covered under hospital inpatient	Covered under hospital inpatient	Covered under hospital inpatient	Covered under hospital inpatient
Residential				
Outpatient	Covered under physician office visits	Covered under physician office visits	Covered under physician office visits	Covered under physician office visits
Chiropractic	Plan pays up to $15 per visit with a maximum of 26 visits during a period of six consecutive months. Dependents are only covered when chiropractic services are used to treat accidental injury. Limited to spinal manipulation only.		If prescribed by a Kaiser physician and medically necessary	Not covered (discounts are available, see website or contact Providence Health Plan for details)

Benefit/Plan Feature	Trust Plan	Kaiser Permanente	Providence Health Plan
Outpatient Prescription Drugs	The Trust has contracted with Kroger Prescription Plans (Kroger) to provide retail prescription drug service.		The Trust has contracted with Kroger Prescription Plans (Kroger) to provide retail prescription drug service.
Retail	**In-network** (Fred Meyer, QFC and Safeway)**:** You pay 10% of the prescription cost with a minimum copay of $10 for generic drugs, and a minimum copay of $20 for preferred brand name drugs. For non-preferred brand name drugs, you pay 20% with a minimum copay of $40. **90-day supply at Fred Meyer or QFC - Option 90** (NOT available at Safeway): You pay a $20 copay for generic drugs; $40 copay for preferred brand name drugs; $80 copay for non-preferred brand name drugs for a 90-day supply of medication. Limited to Fred Meyer and QFC pharmacies. **Out-of-network:** You pay 15% of the prescription cost with a minimum copay of $15 for generic drugs, and a minimum copay of $25 for preferred brand name drugs. For non-preferred brand name drugs, you pay 25% with a minimum copay of $45. **Note:** The plan has a mandatory Class A generic substitution requirement applies to all prescriptions (retail and mail order). If you select a brand name drug when a Class A generic substitute is available, you will be responsible to pay the required generic drug copay ***plus*** the difference in cost between the generic and brand name drug, unless: 1) no generic substitute is available, or 2) your physician provides a letter of medical necessity or pre-authorization. In either of the above situations, you would simply pay the preferred brand name copay.	You pay a $15 copay for generic drugs for formulary brand name drugs. Non-formulary drugs are not covered.	**In-network** (Fred Meyer, QFC and Safeway): You pay 10% of the prescription cost with a minimum copay of $10 for generic drugs, and a minimum copay of $20 for preferred brand name drugs. For non-preferred brand name drugs, you pay 20% with a minimum copay of $40. **90-day supply at Fred Meyer or QFC – Option 90** (NOT available at Safeway): You pay a $20 copay for generic drugs; $40 copay for preferred brand name drugs; $80 copay for non-preferred brand name drugs for a 90-day supply of medication. Limited to Fred Meyer and QFC pharmacies. **Out-of-network:** You pay 15% of the prescription cost with a minimum copay of $15 for generic drugs, and a minimum copay of $25 for preferred brand name drugs. For non-preferred brand name drugs, you pay 25% with a minimum copay of $45.
			Note: The plan has a mandatory Class A generic substitution requirement applies to all prescriptions (retain and mail order). If you select a brand name drug when a Class A generic substitute is available, you will be responsible to pay the required generic drug copay ***plus*** the difference in cost between the generic and brand name drug, unless: 1) no generic substitute is available, or 2) your physician provides a letter of medical necessity or pre-authorization. In either of the above situations, you would simply pay the preferred brand name copay.

Benefit/Plan Feature	Trust Plan	Kaiser Permanente	Providence Health Plan
Outpatient Prescription Drugs *(cont.)*			
Mail Order	You pay a $20 copay for generic drugs; $40 copay for preferred brand name drugs; $80 copay for non-preferred brand name drugs.	90-day supply at two copayments for maintenance medications and a 30-day supply at one copayment for non-maintenance medications.	You pay a $20 copay for generic drugs; $40 copay for preferred brand name drugs; $80 copay for non-preferred brand name drugs.
Annual Out-of-Pocket Maximum	**In-network:** $1,000 per person. Once you have reached your out-of-pocket maximum for prescription drugs, the Plan pays 100%. Includes Option 90 and Mail Order claims. **Out-of-network:** $1,500 per person. Once you have reached your out-of-pocket maximum for prescription drugs, the Plan pays 100%. Includes Mail Order claims.	None	**In-network:** $1,000 per person. Once you have reached your out-of-pocket maximum for prescription drugs, the Plan pays 100%. Includes Option 90 and Mail Order claims. **Out-of-network:** $1,500 per person. Once you have reached your out-of-pocket maximum for prescription drugs, the Plan pays 100%. Includes Mail Order claims.

IMPORTANT: *This summary is intended for* ***comparison*** *purposes only and is not intended to be called upon as a complete explanation of your benefits. In cases of claim dispute, the actual plan document of each plan will prevail. All Indemnity Plan benefit payments are based on Usual, Customary, and Reasonable charges or scheduled benefits.*

Please contact the Plan Administrator at 503-238-6961 or toll-free 1-866-230-6313, if you have questions.

Teamsters 206 Employers Trust

February 1, 2020 - **Comparison** Summary of Welfare Plan Benefits - **Dental Plan A**

Benefit/Plan Feature	Trust Plan	Kaiser Permanente	Providence Health Plan
Annual Deductible			Can select Trust or Kaiser plan
Individual	$50	$50	
Family	$150	$150	
Annual Benefit Maximum[(1)]	$1,250	$1,000 (Part A not included)	
Part A Benefits			
Oral Exams	Plan pays 80% after the deductible	Plan pays 80% no deductible	
Fluoride Application			
X-Rays			
Cleanings			
Space Maintainers			
Tooth Sealants			
Part B Benefits			
Apicoectomy	Plan pays 80% after the deductible	Plan pays 80% after the deductible	
Endodontics; Pulpal Therapy			
Extractions			
Fillings			
Oral Surgery			
Periodontics			
Anesthetics – for Surgical Procedures			
Repair of Prosthetics			
Part C Benefits			
Crowns, Bridges	Plan pays 50% after the deductible	Plan pays 50% after the deductible	
Inlays, Onlays			
Prosthetics			
Orthodontia Benefits – Part D			
Orthodontic Services and Supplies	Not covered	Not covered	

1) Annual maximum does not apply to enrolled children under age 18.

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Please contact Moda Health toll-free 1-800-452-1058, if you have questions.

Teamsters 206 Employers Trust

February 1, 2020 - **Comparison** Summary of Welfare Plan Benefits - **Vision**

Benefit/Plan Feature	Trust Plan VSP Vision Plan		Kaiser Permanente	Providence Health Plan
	Your vision plan is funded by the Teamsters 206 Employers Trust. Your benefits may vary, depending upon whether you choose to see a VSP ® participating provider or non-participating provider.		The same as Trust Plan	The same as Trust Plan
Annual Deductible	None			
	VSP Network Doctor	**Non-VSP Provider**		
Eye Examinations:				
Exam Frequency	One each 12 consecutive months from your last date of service	One each 12 consecutive months from your last date of service	Included in Medical Plan ($25 per exam every 12 months)	Included in Medical Plan ($10 exam for adults, covered in full for children, Frequency: every 12 months)
Benefit Allowance(1)	Paid in full	Up to $50		
Prescription Lenses (when vision exam indicates new lenses are necessary):	One pair per 12 consecutive months from your last date of service	One each 12 consecutive months from your last date of service		
Single Vision Lenses	In full	Up to $50		
Lined Bifocals	In full	Up to $75		
Lined Trifocals	In full	Up to $100		
Contacts (in lieu of glasses)	Up to $60 copay for contact lens exam (fitting and evaluation) $155 allowance for contacts	Up to $155		
Frames – when lenses are prescribed	One each 24 consecutive months from your last date of service	One each 24 consecutive months from your last date of service		
Frame Benefit Allowance	Covered up to $155 allowance. (20 percent discount off any additional out-of-pocket costs.)	Up to $70		

1) Benefit Allowance does not apply to enrolled children under age 18.

Note: "In Full" refers to the full charge for lenses and frames which are necessary for visual welfare. Cosmetic "extras" and frames which exceed the plan allowance are not covered.

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Teamsters 206 Employers Trust

February 1, 2020 - **Comparison** Summary of Welfare Plan Benefits - **Life, AD&D, and Disability**

Benefit/Plan Feature	Trust Plan	Kaiser Permanente	Providence Health Plan
TERM LIFE AND AD&D			
Life Benefit Amount	$4,000	Same as Trust Plan	Same as Trust Plan
Accident, Death & Dismemberment Amount	$4,000 *For Dismemberment:* Scheduled benefit		
WEEKLY DISABILITY			
Weekly Benefit	$200 for each of the first 13 weeks $235 for each of the last 13 weeks		
Benefits Begin:			
For disability due to accident:	1st day		
For disability due to illness:	8th day		
Maximum Benefit Period	26 weeks		

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