WESTERN STATES HEALTH & WELFARE TRUST FUND OF THE OPEIU
2025 PLAN YEAR: ACTIVE EMPLOYEE BENEFIT OPTIONS

Providers / Hospitals	REGENCE BLUECROSS BLUESHIELD OF OREGON			KAISER PERMANENTE
	Preferred Providers (PPO)	Participating Providers	Non-PPO/Participating [1]	Kaiser Permanente providers & contracted facilities
Calendar Year (CY) Maximum	None			None
Calendar Year (CY) Deductible	$300 per individual - $600 per family			None
Medical Calendar Year (CY) Out-of-Pocket Maximum (OOPM)	$3,000 per individual $6,000 per family		$6,000 per individual $12,000 per family	$3,500 per individual $7,000 per family
Provider Office/Clinic Visit	**MEMBER PAYS after deductible (unless otherwise noted with * = deductible waived):**			**MEMBER PAYS:**
▪ Primary care (injury or illness)	▪ $20 copay / visit [2]*	▪ $20 copay / visit *	▪ 40%	▪ $15 copay / visit [3, 4]
▪ Telehealth (phone/video)	▪ $10 copay / visit*	▪ $20 copay / visit*	▪ 40%	▪ No cost share
▪ Specialist	▪ $20 copay / visit*	▪ $20 copay / visit*	▪ 40%	▪ $15 copay / visit
▪ Other practitioner (Acupuncture, Chiropractor)	▪ 20%* [5]	▪ 20%* [5]	▪ 20%* [5]	▪ $10 copay / visit [6]
Preventive Care	▪ No cost share*	▪ No cost share*	▪ 40% [7]	▪ No cost share
Outpatient Testing				
▪ Diagnostic tests (x-ray, blood work)	▪ 20%*	▪ 40%	▪ 40%	▪ $20 copay / visit
▪ Imaging (CT/PET scans, MRIs)	▪ 20%*	▪ 40%	▪ 40%	▪ $20 copay / visit
Prescription Drugs				
▪ Calendar year RX out-of-pocket maximum (OOPM)	▪ $4,300 per individual			▪ None *(accumulates under medical OOPM)*
▪ Value medications	▪ Retail and Mail Order: $0 copay (Optimum Value Medications)			▪ Specific list of medications applies
▪ Generic medications	▪ Retail: $10 or 20% (whichever is greater); Mail Order: $20 or 20% (whichever is greater)			▪ Retail: $15 copay; Mail Order: $30 copay
▪ Preferred brand medications	▪ Retail: $20 or 20% (whichever is greater); Mail Order: $40 or 20% (whichever is greater)			▪ Retail: $30 copay; Mail Order: $60 copay
▪ Non-preferred brand medications	▪ Retail & Mail Order: 50%			▪ Retail: $50 copay; Mail Order: $100 copay
▪ Specialty medications	▪ Paid according to their formulary designation			▪ Paid according to their formulary designation
Outpatient surgery				
▪ Facility fee	▪ 20% [8]	▪ 40%	▪ 40%	▪ No cost share
▪ Physician/surgeon fees	▪ 20%	▪ 40%	▪ 40%	▪ $15 copay / procedure
Emergency Care				
▪ Emergency Room	▪ $75 copay / visit, then 20%	▪ $75 copay / visit, then 20%	▪ $75 copay / visit, then 20%	▪ $75 copay / visit
▪ Emergency medical transportation	▪ 20%	▪ 20%	▪ 20%	▪ $75 copay / transport
▪ Urgent care	▪ $20 copay / visit [9]	▪ $20 copay / visit [8]	▪ 40%	▪ $15 copay / visit
Hospital				
▪ Facility fee	▪ 20%	▪ 40%	▪ 40%	▪ $100 copay/day ($500 max/CY)
▪ Physician/surgeon fee	▪ 20%	▪ 40%	▪ 40%	▪ No cost share
Mental Health/Substance Abuse				
▪ Inpatient services	▪ 20%	▪ 20%	▪ 40%	▪ $100 copay/day ($500 max/CY)
▪ Outpatient services	▪ $20 copay / visit [2]*	▪ $20 copay / visit *	▪ 40%	▪ $15 copay / visit
Maternity				
▪ Prenatal and postnatal care	▪ 20%	▪ 40%	▪ 40%	▪ $15 office visit copay [10]
▪ Delivery and all inpatient services	▪ 20%	▪ 40%	▪ 40%	▪ $100 copay/day ($500/CY)
Recovery or special health needs				
▪ Home health care [11]	▪ 20%	▪ 40%	▪ 40%	▪ No cost share
▪ Rehabilitation services (OT, PT, ST)	▪ 20% [12]	▪ 40% [12]	▪ 40% [12]	▪ $15 office visit copay (20 visits/therapy/CY)
▪ Skilled nursing care	▪ 20%	▪ 40%	▪ 40%	▪ No cost share
▪ Durable medical equipment	▪ 20%	▪ 40%	▪ 40%	▪ 20%

[1] Members may be balanced billed for balances beyond any deductible and coinsurance amounts.
[2] The first three mandated primary care/behavioral health (Preferred providers only) office visit or psychotherapy visits are covered after a $5 copay. Regular plan cost shares apply for subsequent visits.
[3] First preventive care visits each year, either virtually or in-person covered at no member cost share.
[4] First three visits each year for primary care or primary care related services are covered after a $5 copay per visit.
[5] Chiropractic spinal manipulations visits are limited to 30 visits and are combined with osteopathic spinal manipulation visits for a combined 30 visits per calendar year. Acupuncture visits are limited to 30 visits per calendar year.
[6] Chiropractic care is limited to 20 visits per calendar year. Self-referred acupuncture is limited to 12 visits per calendar year. Copays do not apply to the out-of-pocket maximum (OOPM).
[7] Immunizations for children up to age 18 are covered in full.
[8] Coinsurance is reduced to 10% when in-network Preferred Provider Ambulatory Surgical Centers are used.
[9] Members are responsible for their portion of any ancillary charges, e.g., x-rays, lab work, and outpatient surgery.
[10] Prenatal care is considered preventive, therefore there is no cost share and the copay does not apply.
[11] Up to 130 visits per year.
[12] Inpatient: 60-day limit/CY; Outpatient: 45 visit limit/CY (combined limit includes occupational therapy (OT), physical therapy (PT), and speech therapy (ST)).