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)).

VISION COVERAGE			
	VISION SERVICE PLAN (VSP) – REGENCE MEMBERS		**KAISER PERMANENTE MEMBERS [13]**
Providers	VSP Signature network	Non-VSP Providers [14]	Kaiser Permanente Providers only
	MEMBER PAYS:	**MEMBER PORTION/REIMBURSEMENT:**	**MEMBER PAYS:**
Exams	$20 Copay Diabetic eyecare: $20 copay	$20 copay, then reimbursed up to $50	$15 copay
Lenses ▪ Single ▪ Bifocal - Lined ▪ Trifocal - Lined	$25 Copay [15]	$25 copay, then reimbursed: ▪ Up to $50 ▪ Up to $75 ▪ Up to $100	Allowance of $175 for lenses, frames or contacts If full allowance is not used, the balance is forfeited.
Frames	Allowance of $150	Reimbursed up to $70	
Contact Lenses (in lieu of Frames/Lenses)	Allowance of $150 for contacts Up to $60 copay for contact lens exam	Reimbursed up to $105	
Frequency (based on last date of service) ▪ Exam ▪ Lenses ▪ Frames	 ▪ 12 months ▪ 12 months ▪ 24 months	 ▪ 12 months ▪ 12 months ▪ 24 months	 ▪ No limit ▪ Two (2) calendar years ▪ Two (2) calendar years

DENTAL COVERAGE			
DENTAL	**TRUST PLANS**	**WILLAMETTE DENTAL INSURANCE, INC. [16]**	**KAISER PERMANENTE [17]**
Dental Provider	Any licensed Dentist	Willamette Dental Providers only	Kaiser Permanente dentist's
Dental Calendar Year (CY) Deductible	$10 per individual	None	None
Dental General Office Visit Copay	None	$10 copay / visit	$5 copay / visit
Dental Specialist Office Visit Copay	None	$30 copay / visit	$5 copay / visit
Calendar Year (CY) Benefit Maximum	***$1,500 – PLAN PAYS***	None [18]	None
	MEMBER PAYS after deductible:	**MEMBER PAYS:**	**MEMBER PAYS:**
Services ▪ Preventive Care (exams, cleanings) ▪ Basic (fillings, simple extractions) ▪ Prosthetic (crowns, bridges, dentures) ▪ Implant Surgery	 ▪ 20% of UCR ▪ 20% of UCR ▪ 20% of UCR [19] ▪ Not covered	 ▪ $10 copay ▪ $10 copay + applicable copay [20] ▪ $10 copay + applicable copay [20] ▪ $1,500 annual benefit maximum	 ▪ $5 copay ▪ $5 copay + 20% ▪ $5 copay + 50% ▪ Not covered
ORTHODONTIA ▪ Services	 ▪ 50% of UCR	 ▪ $2,400 initial fee, $10 office copay, each visit	 ▪ $5 visit charge + 50%
Orthodontia Lifetime Maximum	$1,000 – ***PLAN PAYS***	None	50% up to $1,000 – ***PLAN PAYS***

Please note: This is a summary of benefits only, for general comparison. Any errors or omissions are purely unintentional. Should any discrepancies be found between this comparison and the plan document, the information in the plan document shall prevail.

[13] Coverage shown is for members age 19 and older. Pediatric vision coverage for children 18 and younger is different; refer to the Kaiser medical summary for more information.
[14] Services and eyewear obtained through out-of-network providers are subject to the same limitations as services obtained through VSP doctors.
[15] Standard progressive lenses are covered in full.
[16] Willamette Dental Insurance, Inc. is available to Oregon, Washington and Idaho residents only.
[17] Kaiser dental is available to all members – one does not need to be enrolled on Kaiser medical.
[18] Benefits for implant surgery have a benefit maximum.
[19] Actual benefit varies, refer to your labor contract.
[20] Applicable copays vary based on services received.