Reta ... A Catholic Healthcare Trust

Archdiocese of Portland in Oregon
Reta Trust Kaiser EPO Plan Comparison

Plan Design	**Reta Kaiser Permanente EPO $0 Ded / $15 OV $1,500 OOP**	
	In Network	**Out of Network**
Annual Out-of-Pocket Maximum (Includes Deductible, Copays & Coinsurance)		
For any one Member in the same Family Unit	**$1,500**	**No coverage**
For an entire Family Unit of two or more Members	**$3,000**	**No coverage**
In Network Deductible	**None**	**No coverage**
Out of Network Deductible	**No coverage**	
Professional Services		
Office Visit Co-payments	**$15 copay**	**No coverage**
Well Child Care (Birth to age 7)	**No charge**	**No coverage**
Adult Routine Exams and Preventive Services (mammograms, Pap smears, & prostate cancer screenings)	**No charge**	**No coverage**
Chiropractic Care	**No coverage**	
Outpatient Services		
Outpatient surgery	**$15 copay**	**No coverage**
X-rays and lab tests	**No charge**	**No coverage**
MRI, CT and PET	**No charge**	**No coverage**
Inpatient Services		
Room and board, surgery, anesthesia, X-rays, lab tests, and drugs	**$250 per admission**	**No coverage**
Non-preauthorized admissions	**N/A**	
Emergency Health Coverage		
Emergency Department visits	**$100 copay** ***copay waived if admitted***	
Prescription Drug	**RX provided through Kaiser**	
	Generic/Formulary	
Retail	**$10/$20**	
Mail Order	**$20/$40**	

IMPORTANT NOTE: This comparison is designed to be a brief overview of the health plan offerings of the Reta Trust. See the plan description for a full description of covered provisions, limitations and exclusion, including customary and reasonable (UCR) charges.

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The Exclusive Provider Organization (EPO) Plan from Kaiser Permanente
Reta Trust – Archdiocese of Portland Employee Benefit Summary

The services described below are covered only if all of the terms and conditions in the *Summary Plan Description* are satisfied.

PLAN FEATURES	
Annual out-of-pocket maximum for certain services Per person/Per family	**$1500/$3000**
Professional services	**YOU PAY**
Routine preventive physical exams	**$0**
Primary care (includes urgent care)	**$15**
Well-child preventive care visits	**$0**
Family planning visits (Counseling and instruction in natural family planning)	**$0**
Scheduled prenatal care visits and first postpartum visit	**$0**
Routine vision exams (refractive)	**$0**
Routine hearing tests	**$0**
Physical, occupational, and speech therapy visits (unlimited visits per Plan year)	**$15**
Outpatient services	
Outpatient surgery and certain other outpatient procedures	**$15**
Allergy injections (during an office visit – office visit cost share will also apply)	**$0**
Allergy injections (without an office visit)	**$5**
Allergy testing visits	**$15**
Non-routine vaccines (immunizations) (during an office visit – office visit cost share will also apply)	**$0**
Non-routine vaccines (immunizations) (without an office visit)	**$0**
X-rays and lab tests	**$0**
Hospitalization services, per admission	
Room and board, surgery, anesthesia, X-rays, lab tests, and drugs	**$250**
Emergency health coverage	
Emergency Department visits (copay waived if admitted)	**$100**
Ambulance services	
Ambulance services (per trip)	**$50**
Infertility services	
Infertility office visits and infertility treatments	**Not covered**
Infertility diagnostic lab tests, X-rays, and surgery	**Not covered**
Prescription drug coverage (covered in accordance with Northwest Formulary guidelines)[1]	
Participating pharmacies generic	**$10**/ Up to 30 day supply
Participating pharmacies brand	**$20**/ Up to 30 day supply
Mail-order generic	**$10**/Up to 30 day supply; **$20** 31 – 90 day supply
Mail-order brand	**$20**/Up to 30 day supply; **$40** 31 – 90 day supply

[1] Infertility, Weight Loss, Contraceptive and Emergency Contraceptive Drugs and devices not covered. Smoking Cessation covered at no charge.

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Mental health services	
Inpatient psychiatric hospitalization, residential treatment, per admission	**$250**
Outpatient individual visits	**$15**
Outpatient group visits	**$7**
Chemical dependency services	
Inpatient hospitalization, per admission	**$250**
Residential treatment	**$100**
Outpatient individual visits	**$15**
Outpatient group visits	**$7**
Home health services	
Home health care (up to 100 visits per Calendar year)	**$0**
Other	
Dialysis visits	**$15**
Health Education	**$15**
Nutrition visits	**$15**
Bariatric Surgery	**Same cost share as other services**
Transgender Surgery	**Same cost share as other services**
Skilled nursing facility care (up to 100 days per Calendar year)	**$0**
Hospice care[2]	**$0**
Durable Medical Equipment, Prosthetics and Orthotics (covered in accordance with Northwest Formulary guidelines)	**20%**
Medically Necessary Eyewear - Glasses[3]	**No charge**

This chart is a summary. It does not explain maximums, exclusions, or limitations, nor does it list all benefits and cost sharing. For a complete description of your Plan, please refer to the *Summary Plan Description.*

Your health benefits are self-insured by your employer, union, or Plan sponsor. Kaiser Permanente provides only administrative services for the Plan and is not an insurer of the Plan or financially liable for health care benefits under the Plan.

[2] Respite care limits: 5 days per month
[3] For diagnoses of aniridia and aphakia up to age 12 after cataract surgery

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Reta Trust - Archdiocese of Portland

EPO **Oregon** Benefit Summary
KP Use only: Plan IDs
Effective Date: 07/01/2016 - 6/30/2017

This is a Benefit Summary for your Kaiser Permanente EPO Plan

OVERALL PLAN FEATURES

Plan Accumulation Type	Calendar Year	
Annual Out of Pocket Maximum Per Person Per Family Each family member has an individual Out-of-Pocket Maximum amount within the family Out-of-Pocket Maximum. The individual cannot contribute to the family Out-of-Pocket Maximum more than the amount of a single Out-of-Pocket Maximum.]	 **$1,500** **$3,000**	
Copays: One Copay per provider is charged per day.		
Visits: One visit counted per day		

ROUTINE PREVENTIVE EXAMS AND SERVICES

Preventive Lab and Xray screenings not specifically listed under the Preventive Screenings section are treated the same as non-preventive Lab and Xray Services. See Preventive Services Listing, Screenings and Immunizations for a comprehensive list of Covered Services. Frequency and Age Limits managed by Network Provider except where noted

Benefit Type	You Pay and/or Maximums	Applies to OOP
Wellness Exams – Adults (Including Well Woman) Includes vision and hearing screenings. See Vision Exams for Refractions and Hearing Exams for audiologic testing.	**$0**	**N/A**
Wellness Exams – Children Includes vision and hearing screenings. See Vision Exams for Refractions and Hearing Exams for audiologic testing.	**$0**	**N/A**
Preventive Screenings	**$0**	**N/A**
Immunizations (Preventive) Coverage applies to Adults and Children.	**$0**	**N/A**

OUTPATIENT SERVICES (Office or Outpatient Facility)

Primary Care Cost Share will be charged for Family Practice, General Internal Medicine, General Pediatrics, ~~Obstetrics and Gynecology specialties and Dieticians~~. Specialty Care Cost Share will be charged for visits with all other medical specialties except Mental Health providers are considered to be Primary Care providers for the purposes of determining Participant cost share.

Benefit Type	You Pay and/or Maximums	Applies to OOP
Office Visits		
Office Visit	**$15**	**Yes**
Allergy		
Office Visit	**$15**	**Yes**
Injection as part of an office visit (Includes serum)	**$0**	**N/A**
Injection only (administration and materials) in the absence of an office visit)	**$5**	**Yes**
Testing	**$15**	**Yes**
Biofeedback Services Includes Medical and Mental Health Services		
Mental Health provider	**$15**	**Yes**
Medical Services provider.	**$15**	**Yes**
Cardiac Rehab	**$15**	**Yes**

OUTPATIENT SERVICES (Office or Outpatient Facility) cont'd		
Benefit Type	**You Pay and/or Maximums**	**Applies to OOP**
Chemotherapy Services		
Office Visit	**$0**	**N/A**
Injectibles/Infusibles	**$0**	**N/A**
Dialysis Services	**$15**	**Yes**
Family Planning		
Counseling and instruction in natural family planning	**$0**	**N/A**
All other family planning services	**Not covered**	**N/A**
Implantable or injectable contraceptives	**Not covered**	**N/A**
Health Education Applicable Office Visit Cost Share based on provider type. Services include: diabetic counseling, diabetic and other outpatient self-management training and education, medical nutritional therapy for diabetes, post coronary counseling and nutritional counseling.		
Office Visit	**$15**	**Yes**
Hearing Exam Includes audiometry exam	**$0**	**N/A**
House Calls		
Office Visit	**$0**	**N/A**
Infusion Services Requires skilled or medical administration.		
Office Visit	**$15**	**Yes**
Provided during an Office Visit	**$0**	**N/A**
Infusion only (Cost of administration and materials or Office Visit Cost Share, whichever is less)	**$0**	**N/A**
Injections, Administered Medications and Immunizations (Non-Routine) Office Visit or in the Nurse Treatment Room		
Office Visit	**$15**	**Yes**
Provided during an Office Visit	**$0**	**N/A**
Injection only (administration and materials) in the absence of an office visit)	**$0**	**N/A**
Travel Clinic - Travel Related Services including consults and immunizations (Japanese Encephalitis, Typhoid, Yellow Fever)		
Office Visit	**$15**	**Yes**
Provided during an Office Visit	**$0**	**N/A**
Injection only (Cost of administration and materials or Office Visit Cost Share, whichever is less)	**$0**	**N/A**
Nutrition Visits	**$15**	**Yes**
Radiation Therapy	**$0**	**N/A**
Respiratory/Pulmonary Therapy	**$15**	**Yes**
TMJ/TMD Therapy		
Office Visit	**$15**	**Yes**
Vision Refraction Exam		
Office Visit (Optometry)	**$0**	**N/A**
Office Visit (Ophthalmology)	**$0**	**N/A**
NOTE: Medical care for eye illness or injury are covered under the medical benefit by provider specialty		

HOSPITAL / SURGERY SERVICES

Benefit Type	You Pay and/or Maximums	Applies to OOP
Inpatient Hospital Includes room and board for private and semi-private rooms; ICU/CCU, Acute Rehab, Inpatient Professional Services, Medically Necessary Private Duty Nursing, Ancillary Services, and Supplies.		
Per admission	**$250**	**Yes**
Ambulance		
Emergency Ground and Air Ambulance	**$50**	**Yes**
Scheduled Ground Ambulance	**$50**	**Yes**
Non-Network or Network Hospital to Network Hospital (repatriation)	**No charge**	
Emergency Services Accident and Illness Copay waived if admitted	**$100**	
Urgent and After Hours Care Urgent Care and After Hours settings	**$15**	**Yes**
Outpatient Surgery Performed in Outpatient Hospital or Ambulatory Surgery Center.	**$15**	**Yes**
Abortion		
Office Visit	**Not covered**	**N/A**
Outpatient Surgery	**Not covered**	**N/A**
Inpatient Hospital per admission	**Not covered**	**N/A**
Bariatric Surgery		
Office Visit	**$15**	**Yes**
Outpatient Surgery	**$15**	**Yes**
Inpatient Hospital per admission	**$250**	**Yes**
Temporomandibular Surgery (TMD/TMJ)		
Office Visit	**$15**	**Yes**
Outpatient Surgery	**$15**	**Yes**
Inpatient Hospital per admission	**$250**	**Yes**
Organ Transplants Includes organ acquisition, diagnostic testing for donor and recipient		
Office Visit	**$15**	**Yes**
Outpatient Surgery	**$15**	**Yes**
Inpatient Hospital per admission	**$250**	**Yes**
Travel and Lodging for Organ Transplants For recipient, care-giver, and donor		
Transportation Limits	None	N/A
Lodging Limits	None	N/A
Daily Expense Limits	Reimbursement up to $50 per day per person	N/A
Daily expenses include incidental expenses such as meals and does not include personal expenses.		
Benefit Maximum	None	N/A
Benefit Lifetime Maximum	None	N/A

MATERNITY

Benefit Type	You Pay and/or Maximums	Applies to OOP
Routine Pre-Natal and Post-Partum Care		
Pre-natal and first post-partum visit	**$0**	**N/A**
Hospital Inpatient		
Per admission	**$250**	**Yes**

DIAGNOSTIC TESTS & PROCEDURES

Includes Preventive Lab and Xray screenings not specifically listed under Preventive Screenings: These Services are treated the same as Lab and Xray

Benefit Type	You Pay and/or Maximums	Applies to OOP
Diagnostic Lab & Xray	**$0**	**N/A**
High Tech/Advanced Radiology - CT, MRI, Nuclear Medicine and PET	**$0**	**N/A**
Special Procedures	**$0**	**N/A**

INFERTILITY SERVICES

Benefit Type	You Pay and/or Maximums	Applies to OOP
Hospital Charges	Not covered	**N/A**
Office Visit	Not covered	**N/A**
Diagnostic Lab & Xray	Not covered	**N/A**
Outpatient hospital or Ambulatory Surgery Center (ASC)	Not covered	**N/A**

MENTAL HEALTH & CHEMICAL DEPENDENCY SERVICES

Benefit Type	You Pay and/or Maximums	Applies to OOP
Mental Health - Inpatient and Residential Treatment		
Per admission	**$250**	**Yes**
Partial Hospitalization	**$0 per day**	**N/A**
Mental Health - Intensive Outpatient Includes all Services provided during the day	**$0 per day**	**N/A**
Mental Health – Outpatient/Office		
Individual Visit Cost Share	**$15**	**Yes**
Group Visit Cost Share	**$7** per day	**Yes**
Chemical Dependency --Inpatient		
Per admission	**$250**	**Yes**
Chemical Dependency --Residential Treatment		
Per admission	**$100**	
Chemical Dependency - Partial Hospitalization	**$0 per day**	**N/A**
Chemical Dependency - Intensive Outpatient Includes all Services provided during the day.	**$0 per day**	**N/A**
Chemical Dependency – Outpatient/Office		
Individual Visit Cost Share	**$15**	**Yes**
Group Visit Cost Share	**$7** per day	**Yes**

PHYSICAL, OCCUPATIONAL & SPEECH THERAPIES

Outpatient Cost Share for therapies is applied as one Copay per provider per day. Visits are counted on a 'per visit' basis.

Benefit Type	You Pay and/or Maximums	Applies to OOP
Physical Therapy	**$15**	**Yes**
Visit maximum	**Unlimited**	**N/A**
Occupational Therapy	**$15**	**Yes**
Visit maximum	**Unlimited**	**N/A**
Speech Therapy	**$15**	**Yes**
Visit maximum	**Unlimited**	**N/A**

SKILLED CARE

Benefit Type	You Pay and/or Maximums	Applies to OOP
Home Dialysis	**$0**	**N/A**
Home Health Care therapy visits and supplies.	**$0**	**N/A**
Visit maximum	100 visits per calendar year	**N/A**
Home Infusion Infusion materials, drugs and supplies	**$0**	**N/A**
Hospice	**$0**	**N/A**
Respite Care limits	5 days per month	
Skilled Nursing Facility		
Per admission	**$0**	**N/A**
Day maximum	100 days per calendar year	**N/A**

ALTERNATIVE CARE

Benefit Type	You Pay	Applies to OOP
Acupuncture Medically Referred	**$15**	
Visit limits	12 visits per calendar year	**N/A**
Chiropractic Services Medically Referred	**$15**	
Visit limits	Unlimited per calendar year	**N/A**
Naturopathy Medically Referred	**$15**	
Visit limits	Unlimited per calendar year	**N/A**
Massage Therapy Medically Referred	**$15**	
Visit limits	Unlimited per calendar year	**N/A**

OTHER SERVICES

Benefit Type	You Pay	Applies to OOP
Accidental Injury to Teeth Repair of sound and natural teeth directly related to an accidental injury.	**Not covered**	**N/A**
Autism A diagnosis of ASD is required for benefits to apply		
Applied Behavior Analysis (ABA)	**$15**	**Yes**
Age Limit		
Physical Therapy	**$15**	**Yes**
Visit maximum	**Unlimited**	**N/A**
Occupational Therapy	**$15**	**Yes**
Visit maximum	**Unlimited**	**N/A**
Speech Therapy	**$15**	**Yes**
Visit maximum	**Unlimited**	**N/A**
Durable Medical Equipment ***Based on NW Region Formulary***	**20%**	**No**
Prosthetics and Orthotics Colostomy/ostomy and urological supplies. ***Based on NW Region Formulary***	**20%**	**No**
Hearing Aids Mandated for Participants under 18 years of age and qualified dependents Includes tests to determine appropriate model, fitting, counseling, adjustment, cleaning and inspection after warranty is exhausted and any necessary ear mold, part, attachments or accessory for the instrument or device, except batteries & cords	**Not covered**	**N/A**
Special Oral Foods Amino Acid Modified Products	**$0**	**N/A**
Out of Area Student Benefit: Coverage for pharmacy, routine and follow-up care Outside the Kaiser Network (within the U.S.)	**Not covered**	**N/A**
Adult Vision Hardware - Contact Lenses	**Not covered**	**N/A**
Adult Vision Hardware - Frames and Eyeglass Lenses	**Not covered**	**N/A**
Medically Necessary Eyewear		
Glasses or Lenses as Medically Necessary	**$0**	**N/A**

OUTPATIENT PRESCRIPTION DRUGS Must be obtained from Network Pharmacies and on the KP formulary (list of approved drugs), unless otherwise specified		
Benefit Type	**You Pay and/or Maximums**	**Applies to Plan OOP**
2 Tier		
Generic	**$10** up to 30 days supply	**Yes**
Brand	**$20** up to 30 days supply	**Yes**
Mail Order Drugs		
2 Tier Mail Order		
Generic	**$10** up to 30 days supply and **$20** from 31 up to 90 days supply	**Yes**
Brand	**$20** up to 30 days supply and **$40** from 31 up to 90 days supply	**Yes**
Blood Factors	**$0**	**N/A**
Diabetic Coverage - Oral Medications and Insulin - Diabetic testing supplies (test strips) - Diabetic administration devices (syringes, Glucagon emergency kits)	 **=Generic/Brand** **20%** **=Generic/Brand**	 **Yes** **No**
Infertility Drug Coverage	**Not covered**	**N/A**
Growth Hormone	**=Generic/Brand**	**Yes**
Post-surgical immunosupressive drugs after covered transplant	**=Generic/Brand**	**Yes**
Sexual Dysfunction Limit: 8 doses, 30 days	**= Generic/Brand**	**Yes**
Smoking Cessation	**$0**	**N/A**
Weight Loss	**Not covered**	**N/A**
ACA Mandated Drugs*		
Contraceptive Devices (diaphragms, cervical caps, etc.) **and Contraceptive Drugs**	**Not covered**	**N/A**
Emergency Contraception	**Not covered**	**N/A**
Anti-Breast Cancer Drug	**$0**	**N/A**
OTC* Aspirin Oral Fluoride Folic Acid Iron Supplements Vitamin D Female Contraceptives (spermicides, female condoms and sponges, emergency contraceptives)	 **$0** **$0** **$0** **$0** **$0** **Not covered**	 **N/A** **N/A** **N/A** **N/A** **N/A** **N/A**
* With prescription, no cost share. Without prescription, Participant pays retail cost		
For items or injections dispensed by Pharmacy and requiring skilled administration in the Physician's Office (Implantable contraceptives, administered meds, etc.) Office Visit Cost Share for administration may apply.		

Kaiser Permanente Northwest Health Care Reform Preventive Services

Medical plans with plan years beginning on or after January 1, 2015 must cover the following preventive Services without a Copayment, Coinsurance, or Deductible, when these Services are delivered by a Network provider.

Preventive Services for adults

Age-appropriate preventive medical examination
Discussion with Primary Care Provider regarding alcohol misuse
Discussion with Primary Care Provider regarding obesity and weight management
Abdominal aortic aneurysm— screening by ultrasonography in men who have ever smoked
Blood pressure screening for all adults.
Cholesterol screening for adults at higher risk of cardiovascular disease
Colon cancer screening for adults
Prostate cancer screening in men
Depression screening for adults
Type 2 diabetes screening for adults with high blood pressure
Hepatitis C virus screening for persons at high risk of infection and one-time screening for adults
Discussion with Primary Care Provider regarding aspirin for adults at higher risk of cardiovascular disease
Discussion with Primary Care Provider regarding diet counseling for adults at higher risk for chronic disease
Immunizations for adults (doses, recommended ages, and recommended populations vary):
Hepatitis A
Hepatitis B
Herpes zoster
Human papillomavirus
Influenza
Measles, mumps, rubella
Meningococcal
Pneumococcal
Tetanus, diphtheria, pertussis
Varicella
Screening for all adults at higher risk for sexually transmitted infections and counseling for prevention of sexually transmitted infections, including:
HIV
Gonorrhea
Syphilis
Chlamydia
Discussion with Primary Care Provider regarding tobacco cessation
Physical therapy to prevent falls in community-dwelling adults who are at increased risk of falling
Over-the-counter drugs when prescribed by a physician for preventive purposes, including:
Aspirin to reduce the risk of heart attack
Vitamin D supplements for adults to prevent falls
Lung cancer screening including CT scan of the thorax when ordered for smokers
Screening for hepatitis B virus infection in adults and adolescents at high risk for infection(effective 6/1/2015)

Preventive Services for women, including pregnant women

Age-appropriate preventive medical examination
Discussion with Primary Care Provider regarding chemoprevention in women at higher risk for breast cancer
Discussion with Primary Care Provider regarding inherited susceptibility to breast and/or ovarian cancer
Mammography screening for breast cancer for women
Cervical cancer screening in women
Osteoporosis screening for women
Discussion with Primary Care Provider regarding tobacco cessation
Chlamydia infection screening for sexually active women (and men) at higher risk
Gonorrhea screening for all women at higher risk
Syphilis screening for all pregnant women and other women at higher risk
Anemia screening for pregnant women
Urinary tract or other infection screening for pregnant women
Hepatitis B screening for pregnant women at their first prenatal visit
Discussion with Primary Care Provider about folic acid supplements for women who may become pregnant

Rh incompatibility screening for pregnant women and follow-up testing for women at higher risk
Routine prenatal care visits
Discussion with Primary Care Provider regarding preconception care
Discussion with Primary Care Provider about interventions to promote and support breastfeeding and comprehensive lactation support and counseling
Provision of breastfeeding equipment
Gestational diabetes screening for pregnant women between 24 and 28 weeks of gestation and for pregnant women identified to be at high risk for diabetes
Discussion with Primary Care Provider about interpersonal and domestic violence
Over-the-counter folic acid for women to reduce the risk of birth defects when prescribed by a physician for preventive services
For women who have family members with breast, ovarian, tubal, or peritoneal cancer, screening for family history that may be associated with an increased risk for potentially harmful mutations in breast cancer susceptibility genes (BRCA1 or BRCA2)
BRCA genetic testing when clinically indicated after genetic counseling.
Breast Cancer Chemoprevention - Consultation and medications prescribed for risk reduction of primary breast cancer in high-risk women

Preventive Services for children

Age-appropriate preventive medical examination
Medical history for all children throughout development
Height, weight, and body mass index measurements for children
Behavioral assessments for children of all ages by Primary Care Provider
Developmental screening for children and surveillance throughout childhood by Primary Care Provider
Discussion with Primary Care Provider regarding alcohol and drug use assessments for adolescents
Autism screening for children by Primary Care Provider
Cervical dysplasia screening for sexually active females
Congenital hypothyroidism screening for newborns
Phenylketonuria (PKU) screening in newborns
Dyslipidemia screening for children at higher risk of lipid disorders
Oral health risk assessment for young children by Primary Care Provider
Lead screening for children at risk of exposure
Discussion with Primary Care Provider regarding obesity screening and counseling
Gonorrhea prevention medication for the eyes of all newborns
Hearing screening for all newborns
Vision screening for all children
Hematocrit or hemoglobin screening for children
Hemoglobinopathies or sickle cell screening for newborns
Tuberculin testing for children at higher risk of tuberculosis
HIV screening for adolescents at higher risk
Sexually transmitted infection (STI) prevention counseling for adolescents at higher risk
Discussion with Primary Care Provider regarding fluoride supplements for children who have no fluoride in their water source
Application of fluoride varnish to the primary teeth of all infants and children starting at the age of primary tooth eruption
Discussion with Primary Care Provider regarding iron supplements for children who are at risk for anemia
Over-the-counter drugs when prescribed by a physician for preventive purposes:
Iron supplements for children to reduce the risk of anemia
Oral fluoride for children to reduce the risk of tooth decay
Immunizations for children (doses, recommended ages, and recommended populations vary):
Diphtheria, tetanus, pertussis
Haemophilus influenzae type B
Hepatitis A
Hepatitis B
Human papillomavirus
Inactivated poliovirus
Influenza
Measles, mumps, rubella
Meningococcal
Pneumococcal

Rotavirus
Varicella

State-Mandated Preventive Services for Adults and Children/Oregon

Below are lists of state- or region-mandated services. For contracts issued in one of these states or regions, our Health Care Reform Preventive Services Package also includes the services listed for that state or region.

Oregon

Prostate cancer screenings (e.g., prostate-specific antigen testing and digital rectal examination)
First postpartum visit

Additional information about preventive services

Preventive and other Services provided during the same visit

There are some additional things to keep in mind about coverage for mandated preventive Services that are provided along with other Services during the same visit:

The following Cost Share rules apply when a mandated preventive Service is provided during an office visit:

If the preventive Service is billed separately (or is tracked as individual encounter data separately) from the office visit, then cost sharing may apply to the office visit.

If the preventive Service is not billed separately (or is not tracked as individual encounter data separately) from the office visit,

o If the primary purpose of the office visit is the delivery of the preventive service, then no cost sharing may apply to the office

o If the primary purpose of the office visit is not the delivery of the preventive service, then cost sharing may apply to the office

Note: The Preventive List is subject to changes based on new Federal recommendations (and clinical interpretations) issued after the date of this document

Reta Trust

General Exclusions

Acupuncture. Services for acupuncture are limited to when a Network Provider makes a referral for Services in accord with Medical Group criteria and are subject to benefit limitations (if any) as shown in the “Benefit Summary”.

Certain exams and Services. Physical examinations and other Services are excluded when: (a) required for obtaining or maintaining employment or participation in employee programs, (b) required for insurance or governmental licensing, (c) court ordered or required for parole or probation, or (d) received while incarcerated.

Chiropractic Services are limited to when a Network Provider makes a referral for Services in accord with Medical Group criteria and are subject to benefit limitations (if any) as shown in the “Benefit Summary”.

Cosmetic Services. Cosmetic Services, which means those Services that are intended primarily to change or maintain your appearance and will not result in significant improvement in physical function. This exclusion does not apply to Services that are covered under “Reconstructive Surgery Services”.

Custodial Services. Nonskilled, personal Services such as help with activities of daily living (like bathing, dressing, getting in and out of a bed or chair, moving around and using the bathroom. It may also include care that most people do themselves, like using eye drops. In most cases, Medicare does not pay for Custodial Services.

Dental Services. Dental care including dental Xrays; Dental Services following accidental injury to teeth; dental appliances; dental implants; orthodontia; and Dental Services necessary for or resulting from medical treatment such as surgery on the jawbone and radiation treatment is limited to: (a) emergency Dental Services; or (b) extraction of teeth to prepare the jaw for radiation treatments of neoplastic disease.
General anesthesia and associated hospital or ambulatory surgical facility Services in conjunction with Non-Covered Dental Services are excluded, except when Medically Necessary for Participants who have a medical condition that your Network

Designated Blood Donations. Collection, processing, and storage of blood donated by donors whom you designate, and procurement and storage of cord blood is covered only when Medically Necessary for the imminent use at the time of collection

Detained or Confined Participants. Services provided or arranged by criminal justice officials or institutions for detained or confined Participants are limited to Services which meet the requirements of Emergency Care.

Employer Responsibility. We do not reimburse the employer for any Services that the law requires an employer to provide. When we cover any of these Services we may recover the Charges for the Services from the employer.

Experimental or Investigational Services. Services are excluded if any of the following is true about the Service:
'-They cannot be legally marketed in the United States without the approval of the U.S. Food and Drug Administration (FDA), and the FDA has not granted this approval.
-They are the subject of a current new drug or new device application on file with the FDA.
-They are provided as part of a Phase I, Phase II, or Phase IV clinical trial, as the experimental or research arm of a Phase III clinical trial, or in any other manner that is intended to evaluate the safety, toxicity, or efficacy of the Services.
-They are provided pursuant to a written protocol or other document that lists an evaluation of the Services’ safety, toxicity, or efficacy as among its objectives.
-They are subject to the approval or review of an Institutional Review Board (IRB) or other body that approves or reviews research concerning the safety, toxicity, or efficacy of Services.
-They are provided pursuant to informed consent documents that describe the Services as experimental or investigational, or in other terms that indicate that the Services are being evaluated for their safety, toxicity, or efficacy.
-The prevailing opinion among experts as expressed in the published authoritative medical or scientific literature is that:
 •Use of the Services should be substantially confined to research settings, or
 •Further research is necessary to determine the safety, toxicity, or efficacy of the Services.
In making determinations whether a Service is experimental or investigational, the following sources of information will be relied upon exclusively:
-Your medical records.
-The written protocols and other documents pursuant to which the Service has been or will be provided.
-Any consent documents you or your representative has executed or will be asked to execute, to receive the Service.
-The files and records of the IRB or similar body that approves or reviews research at the institution where the Service has been or will be provided, and other information concerning the authority or actions of the IRB or similar body.
-The published authoritative medical or scientific literature about the Service, as applied to your illness or injury.
-Regulations, records, applications, and any other documents or actions issued by, filed with, or taken by, the FDA or other agencies within the United States Department of Health and Human Services, or any state agency performing similar functions.
We consult Medical Group and then use the criteria described above to decide if a particular Service is experimental or investigational.

Eye Surgery. Radial keratotomy, photorefractive keratectomy, and refractive surgery, including evaluations for the procedures.
Family Services. Services provided by a member of your immediate family.
Genetic Testing. Genetic testing and related Services are limited to genetic counseling and medically appropriate genetic testing for the purpose of diagnostic testing to determine disease and/or predisposition of disease and to develop treatment plans. Covered Services are limited to preconception and prenatal testing for detection of congenital and heritable disorders, and testing for the prediction of high-risk occurrence or reoccurrence of disease when Medically Necessary as determined by a Network Provider, in accordance with applicable law. However, testing for family members who are not Participants is always excluded.
Government Agency Responsibility. We do not reimburse the government agency for any Services that the law requires be provided only by or received only from a government agency. When we cover any of these Services we may recover the Charges for the Services from the government agency. However, this exclusion does not apply to Medicaid.
Hearing Aids. Hearing Aids, tests to determine their efficacy, and hearing tests to determine an appropriate Hearing Aid are excluded. This exclusion does not apply to Services that are covered under “Hearing Services” in the “Benefits” section.
Hypnotherapy. All Services related to hypnotherapy.
Intermediate Services. Services in an intermediate care facility are excluded.
Infertility Services Donor semen, donor eggs, and Services related to their procurement and storage. Drugs, both oral and injectable, used in the treatment of infertility Services related to conception by artificial means, such as in vitro fertilization (IVF), ovum transplants, gamete intrafallopian transfer (GIFT), and zygote intrafallopian transfer (ZIFT), except artificial insemination Services to reverse voluntary, surgically induced infertility
Low-Vision Aids
Massage Therapy Services. Massage therapy and related Services are limited to when a Network Provider makes a referral for Services in accord with Medical Group criteria and are subject to benefit limitations (if any) as shown in the “Benefit Summary”.
Naturopathy Services. Naturopathy and related Services are limited to when a Network Provider makes a referral for Services in accord with Medical Group criteria and are subject to benefit limitations (if any) as shown in the “Benefit Summary”.
Non-Medically Necessary Services. Services that are not Medically Necessary.
Nonreusable Medical Supplies. Nonreusable medical supplies, such as splints, slings, and wound dressing, including bandages and ace wrap bandages, are limited to those supplied and applied by a licensed health care provider, while providing a covered Service. Nonreusable medical supplies that a Participant purchases or obtains from another source are excluded.
Outpatient Prescription Drugs, Supplies, and Supplements Exclusions Any packaging, such as blister or bubble repacking, other than the dispensing pharmacy’s standard packaging. Drugs prescribed for an indication if the U.S. Food and Drug Administration (FDA) determined that use of that drug for that indication is contraindicated. Drugs prescribed for an indication if the FDA has not approved the drug for that indication, except that this exclusion does not apply if the Oregon Health Resources Commission or our Regional Formulary and Therapeutics Committee determines that the drug is recognized as effective for that use (i) in one of the standard reference compendia, or (ii) in the majority of relevant peer-reviewed medical literature, or (iii) by the Secretary of the U.S. Department of Health and Human Services. Drugs, supplies, and supplements that are available without a prescription, even if the nonprescription item is in a different form or different strength (or both), except that this exclusion does not apply to drugs, supplies, or supplements that our drug formulary lists for your condition. Drugs that the FDA has not approved. Drugs used in weight management. Drugs used to enhance athletic performance. Extemporaneously compounded drugs, unless the formulation is approved by our Regional Formulary and Therapeutics Committee. Mail-order drugs for anyone who is not a resident of Oregon or Washington. Replacement of drugs, supplies, and supplements due to loss, damage, or carelessness. Contraceptive drugs and devices including injectable and emergency contraceptives Drugs used in the treatment of infertility
Professional Services for Fitting and Follow-Up Care for Contact Lenses

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General Exclusions

Services performed by Unlicensed People. Services that are performed safely aond effectively by people who do not require licenses or certificates by the state to proide health care Services and where the Participant's condition does not require that the Servcies be provided by a licensed health care provider.
Services related to a Non-Covered Service. When a Service is not covered, all Services related to the Non-Covered Service are also excluded. However, this exclusion does not apply to Services we would otherwise cover if they are to treat complications which arise from the Non-Covered Service and to Medically Necessary Services for a Participant enrolled in and participating in a qualifying clinical trial if we would typically cover those Services absent a clinical trial.
Sexual Reassignment surgery.
Services That are Not Health Care Services, Supplies or Items. For example, we do not cover: '-Teaching manners and etiquette -Teaching and support services to develop planning skills such as daily activity planning and project or task planning. -Items and services that increase academic knowledge or skills. -Teaching and support services to increase intelligence. -Academic coaching or tutoring for skills such as grammar, math, and time management. -Teaching you how to read, whether or not you have dyslexia -Educational testing. -Teaching art, dance, horse riding, music, play or swimming. -Teaching skills for employment or vocational purposes. -Vocational training or teaching vocational skills. -Professional growth courses. -Training for a specific job or employment counseling. -Aquatic therapy and other water therapy.
Supportive care and other Services. Supportive care primarily to maintain the level of correction already achieved; care primarily for the convenience of the Participant; and care on a non-acute, symptomatic basis are excluded.
Surrogacy. Services for anyone in connection with a Surrogacy Arrangement, except for otherwise-covered Services provided to a Participant who is a surrogate. A "Surrogacy Arrangement" is one in which a woman (the surrogate) agrees to become pregnant and to surrender the baby (or babies) to another person or persons who intend to raise the child (or children), whether or not the woman receives payment for being a surrogate. See "Surrogacy Arrangements" for information about your obligations to us in connection with a Surrogacy Arrangement, including your obligations to reimburse us for any Services we cover and to provide information about anyone who may be financially responsible for Services the baby (or babies) receive.
Travel and lodging. Transportation or living expenses for any person, including the patient, are limited to: (a) Medically Necessary ambulance Service covered under “Ambulance Services”, and (b) certain expenses that we Pre-Authorize in accord with our travel and lodging guidelines under “Transplant Services”. Your transplant coordinator can provide information about
Vision Hardware Optical Services. Corrective lenses, eyeglasses, and contact lenses
Vision therapy and Orthoptics or Eye Exercises. Services related to vision therapy and orthoptics and eye exercises are
Source: 2015 Oregon EOC
Added from Reta Trust CA Plans: Abortions - Elective, Medically Necessary and Rape/Incest procedures
Sterilization and Reversal of Sterilization
Source:Customer Exclusions
Blood-The cost of whole red blood or red blood cells when they are donated or replaced or billed, except expenses for administration and processing of Blood and Blood Products (except Blood Factors) covered as part of inpatient and outpatient
Crime-Treatment of injuries sustained while committing a crime
Care in a halfway house
Personal Comfort Items – Personal comfort items such as those that are furnished primarily for your personal comfort or convenience, including those Services and supplies not directly related to medical care, such as guest’s meals and accommodations, hospital admission kit, barber services, telephone charges, radio and television rentals, homemaker services, travel expenses, over the counter convenience items and take-home supplies.
Hypnotherapy (Hypnosis)
Private Duty Nursing as a registered bed patient unless a Plan physician determines medical necessity.
Private Duty Nursing in home or long term facility
Religious, personal growth counseling or marriage counseling including Services and treatment related to religious, personal growth counseling or marriage counseling, unless the primary patient has a DSM IV diagnosis

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General Exclusions

Services provided outside the United States-Services, other than Emergency Services, received outside the United States whether or not the Services are available in the United States
Equipment: that basically serves comfort or convenience functions or is primarily for the convenience of a person caring for you or your Dependent, i.e., exercycle or other physical fitness equipment, elevators, hoyer lifts, shower/bath bench, air conditioners, air purifiers and filters, batteries and charges, dehumidifiers, humidifiers, air cleaners and dust collection devices.