Reta ... A Catholic Healthcare Trust

Archdiocese of Portland in Oregon
Reta Trust UHC 250 & 500 Plan Comparison

	Reta United Healthcare 250 PPO $250 Ded / $20 OV $500 OOP		Reta United Healthcare 500 PPO $500 Ded / $25 OV $2,500 OOP	
	In Network	**Out of Network**	**In Network**	**Out of Network**
Annual Out-of-Pocket Maximum (Includes Deductible, Copays & Coinsurance)				
For any one Member in the same Family Unit	**$500**	**$1,000**	**$2,500**	**$5,000**
For an entire Family Unit of two or more Members	**$1,000**	**$2,000**	**$5,000**	**$10,000**
Calendar Year Deductible	**$250 Individual / $500 Family**		**$500 Individual / $1,000 Family**	
Outpatient Services				
Office Visit Co-payments	**$20 copay, deductible waived**	**30%**	**$25 copay, deductible waived**	**40%**
Specialist Office Visit Co-payments	**$35 copay, deductible waived**	**30%**	**$40 copay, deductible waived**	**40%**
Well Child Care (Birth to age 7)	**No charge, deductible waived**	**30%**	**No charge, deductible waived**	**40%**
Adult Routine Exams	**No charge, deductible waived**	**30%**	**No charge, deductible waived**	**40%**
Chiropractic Care	**$35 copay, deductible waived** *Up to 24 visits in calendar year*	**30%**	**$40 copay, deductible waived** *Up to 24 visits in calendar year*	**40%**
Outpatient Services				
Outpatient surgery	**10%**	**30%**	**20%**	**40%**
X-rays and lab tests	**10%**	**30%**	**20%**	**40%**
MRI, CT and PET	**10%**	**30%**	**20%**	**40%**
Inpatient Services				
Room and board, surgery, anesthesia, X-rays, lab tests, and drugs	**10%**	**30%**	**20%**	**40%**
Non-preauthorized admissions	**Prior Authorization Required**		**Prior Authorization Required**	
Emergency Health Coverage				
Emergency Department visits	**$100 copay, then 10%** *copay waived if admitted*	**$100 copay, then 10%**	**$200 copay, then 20%** *copay waived if admitted*	**$200 copay, then 20%**
Prescription Drug	**RX provided through EnvisionRx****			
	Generic/Formulary/Non-Formulary		**Generic/Formulary/Non-Formulary**	
Retail (Up to 30-day supply)	**$10/$20/$30**		**$10/$20/$30**	
Mail Order (Up to 90-day supply)	**$20/$40/$60**		**$20/$40/$60**	

**Subject to RVO program

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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Updated April 11, 2016

Reta Trust
United Health Care 250
Choice Plus Plan

Reta Trust Self-funded Plan
Archdiocese of Portland, Oregon
Schedule of Benefits
Choice Plus Plan

NOTE: To be a Covered Health Service, a service **must**: meet the requirements for coverage, as described in this SPD; be shown as a Covered Health Service in this SPD; and be consistent with the Ethical and Religious Directives for Catholic Health Care Services ("Directives").

Plan Features	Network	Non-Network
Annual Deductible[1]		
■ Individual	$250 per calendar year	$250 per calendar year
■ Family (cumulative Annual Deductible)	$500 per calendar year	$500 per calendar year
Annual Out-of-Pocket Maximum[1]		
■ Individual	$500 per calendar year	$1,000 per calendar year
■ Family (cumulative Out-of-Pocket Maximum)	$1,000 per calendar year	$2,000 per calendar year
Penalty for Non-Preauthorized Hospital Admission[2]	$500 per admission	
■ **Lifetime Maximum Benefit** There is no dollar limit to the amount the Plan will pay for essential Benefits during the entire period you are enrolled in this Plan.[3]	Unlimited	

[1]The Annual Deductible applies toward the Out-of-Pocket Maximum for all Covered Health Services.

[2]Penalty does not apply toward the Out-of-Pocket Maximum.

[3] Generally the following are considered to be essential benefits under the Patient Protection and Affordable Care Act: Ambulatory patient services; emergency services, hospitalization; maternity and newborn care, mental health and substance use disorder services (including behavioral health treatment); prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care.

Covered Health Services	Percentage of Eligible Expenses Payable by the Plan:	
	Network	**Non-Network**
Acupuncture Services Up to 24 visits per calendar year	100% after you pay a $35 Copay per visit[3]	70% after you meet the Annual Deductible
Ambulance Services - Emergency Only	*Ground Transportation* 90% after you meet the Annual Deductible *Air Transportation* 90% after you meet the Annual Deductible	*Ground Transportation* 90% after you meet the Annual Deductible *Air Transportation* 90% after you meet the Annual Deductible
Cancer Resource Services (CRS) ■ Hospital - Inpatient Stay	90% after you meet the Annual Deductible	Not Covered
Clinical Trials	Depending upon where the Covered Health Service is provided, benefits for Clinical Trials will be the same as those stated under each Covered Health Service category in this section.	
Dental Services - Accident Only Prior notification required before follow-up treatment begins. See Section 6, *Coverage Details*, for limits	90% after you meet the Annual Deductible	90% after you meet the Annual Deductible
Durable Medical Equipment (DME) See Section 6, *Coverage Details*, for limits	90% after you meet the Annual Deductible	70% after you meet the Annual Deductible. Prior Notification required when cost is more than $1,000.
Emergency Health Services See Section 6, *Coverage Details*, for limits	90% after you pay a $100 Copay per visit[3]; Copay waived if admitted	90% after you pay a $100 Copay per visit[3]; Copay waived if admitted. Notification is required if results in an Inpatient Stay.
Eye Examinations See Section 6, *Coverage Details*, for limits	100% after you pay a $20 Copay per visit[3]	70% after you meet the Annual Deductible
Home Health Care Up to 60 visits per calendar year See Section 6, *Coverage Details*, for limits	90% after you meet the Annual Deductible	70% after you meet the Annual Deductible. Prior Notification required.

Covered Health Services	Percentage of Eligible Expenses Payable by the Plan:	
	Network	**Non-Network**
Hospice Care Up to 360 days per lifetime See Section 6, *Coverage Details*, for limits	90% after you meet the Annual Deductible	70% after you meet the Annual Deductible. Prior Notification required.
Hospital - Inpatient Stay See Section 6, *Coverage Details*, for limits	90% after you meet the Annual Deductible	70% after you meet the Annual Deductible. Prior Notification required.
Injections received in a Physician's Office	100% after you pay a $20 Copay per visit[3]	70% per injection after you meet the Annual Deductible
Kidney Resource Services (KRS) (These Benefits are for Covered Health Services provided through KRS only)	Benefits will be the same as those stated under each Covered Health Service category in this section.	Not Covered
Maternity Services A Deductible will not apply for a newborn child whose length of stay in the Hospital is the same as the mother's length of stay.	Benefits will be the same as those stated under each Covered Health Service category in this section. No copay applies to Physician Office visits for prenatal care after the first visit.	
Mental Health Services ■ Hospital - Inpatient Stay ■ Physician's Office Services See Section 6, *Coverage Details* for limits	90% after you meet the Annual Deductible 100% after you pay a $35 Copay per individual visit[3]; $10 Copay per group visit[3]	70% after you meet the Annual Deductible. Prior notification required through the Mental Health/Substance Use Disorder Administrator. 70% after you meet the Annual Deductible. Prior notification required through the Mental Health/Substance Use Disorder Administrator.
Morbid Obesity Surgery See Section 6, *Coverage Details* for limits	Benefits will be the same as those stated under each Covered Health Service category in this section.	

Covered Health Services	Percentage of Eligible Expenses Payable by the Plan:	
	Network	**Non-Network**
Neurobiological Disorders - Mental Health Services for Autism Spectrum Disorders		
■ Hospital - Inpatient Stay	90% after you meet the Annual Deductible	70% after you meet the Annual Deductible. Prior notification required through the Mental Health/Substance Use Disorder Administrator.
■ Physician's Office Services	100% after you pay a $35 Copay per individual visit[3]; $10 Copay per group visit[3]	70% after you meet the Annual Deductible. Prior notification required through the Mental Health/Substance Use Disorder Administrator.
Outpatient Surgery, Diagnostic and Therapeutic Services		
■ Outpatient Surgery	90% after you meet the Annual Deductible	70% after you meet the Annual Deductible
■ Outpatient Diagnostic Services		
• Preventive Lab and radiology/X-ray	100%	70% after you meet the Annual Deductible
• Preventive mammography testing	100%	70% after you meet the Annual Deductible
• Sickness and Injury related diagnostic services	90% after you meet the Annual Deductible	70% after you meet the Annual Deductible
■ Outpatient Diagnostic/Therapeutic Services - CT Scans, PET Scans, MRI and Nuclear Medicine	90% after you meet the Annual Deductible	70% after you meet the Annual Deductible
■ Outpatient Therapeutic Treatments	90% after you meet the Annual Deductible	70% after you meet the Annual Deductible
Physician's Office Services - Sickness and Injury		
■ Primary Physician	100% after you pay a $20 Copay per visit[3]	70% after you meet the Annual Deductible
■ Specialist Physician	100% after you pay a $35 Copay per visit[3]	70% after you meet the Annual Deductible
Physician Fees for Surgical and Medical Services	90% after you meet the Annual Deductible	70% after you meet the Annual Deductible

Covered Health Services	Percentage of Eligible Expenses Payable by the Plan:	
	Network	**Non-Network**
Preventive Care Services ■ Physician Office Services	100%	70% after you meet the Annual Deductible
■ Outpatient Diagnostic Services	100%	70% after you meet the Annual Deductible
■ Breast Pumps	100%	70% after you meet the Annual Deductible
Prosthetic Devices See Section 6, *Coverage Details*, for limits	90% after you meet the Annual Deductible	70% after you meet the Annual Deductible
Reconstructive Procedures See Section 6, *Coverage Details*, for limits	Benefits will be the same as those stated under each Covered Health Service category in this section	
Rehabilitation Services - Outpatient Therapy See Section 6, *Coverage Details* for limits	100% after you pay a $35 Copay per visit[3]	70% after you meet the Annual Deductible
Skilled Nursing Facility/Inpatient Rehabilitation Facility Services Up to 60 days per calendar year See Section 6, *Coverage Details*, for limits	90% after you meet the Annual Deductible	70% after you meet the Annual Deductible. Prior Notification required.
Spinal Treatment Up to 24 visits per calendar year See Section 6, *Coverage Details*, for limits	100% after you pay a $35 Copay per visit[3]	70% after you meet the Annual Deductible
Substance Use Disorder Services ■ Hospital - Inpatient Stay	90% after you meet the Annual Deductible	70% after you meet the Annual Deductible. Prior notification required through the Mental Health/Substance Use Disorder Administrator.
■ Physician's Office Services	100% after you pay $35 Copay per individual visit[3]; $10 Copay per group visit[3]	70% after you meet the Annual Deductible. Prior notification required through the Mental Health/Substance Use Disorder Administrator.

Covered Health Services	Percentage of Eligible Expenses Payable by the Plan:	
	Network	**Non-Network**
Transplantation Services Notification is required for all transplant services. See Section 6, *Coverage Details*, for limits	Depending upon where the Covered Health Service is provided, benefits will be the same as those stated under each Covered Health Service category in this section.	
Transplantation Travel and Lodging (If services rendered by a Designated Facility) **See Section 6, *Coverage Details*, for limits**	For patient and companion(s) of patient undergoing transplant procedures	
Urgent Care Center Services	100% after you pay a $50 Copay per visit[3]	100% after you pay a $50 Copay per visit[3]

[3] Copays apply toward the Annual Deductible or Out-of-Pocket Maximum. The Annual Deductible applies toward the Out-of-Pocket Maximum for all Covered Health Services.

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Choice Plus Plan

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Plan Features	Network	Non-Network
Annual Deductible[1]		
■ Individual	$500 per calendar year	$500 per calendar year
■ Family (cumulative Annual Deductible)	$1,000 per calendar year	$1,000 per calendar year
Annual Out-of-Pocket Maximum[1]		
■ Individual	$2,500 per calendar year	$5,000 per calendar year
■ Family (cumulative Out-of-Pocket Maximum)	$5,000 per calendar year	$10,000 per calendar year
Penalty for Non-Preauthorized Hospital Admission[2]	$500 per admission	
■ **Lifetime Maximum Benefit** There is no dollar limit to the amount the Plan will pay for essential Benefits during the entire period you are enrolled in this Plan.[3]	Unlimited	

[1]The Annual Deductible applies toward the Out-of-Pocket Maximum for all Covered Health Services.

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[3] Generally the following are considered to be essential benefits under the Patient Protection and Affordable Care Act: Ambulatory patient services; emergency services, hospitalization; maternity and newborn care, mental health and substance use disorder services (including behavioral health treatment); prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care.

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	Network	**Non-Network**
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Ambulance Services - Emergency Only	*Ground Transportation* 80% after you meet the Annual Deductible *Air Transportation* 80% after you meet the Annual Deductible	*Ground Transportation* 80% after you meet the Annual Deductible *Air Transportation* 80% after you meet the Annual Deductible
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Home Health Care Up to 60 visits per calendar year See Section 6, *Coverage Details*, for limits	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible. Prior Notification required.

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■ Outpatient Therapeutic Treatments	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Physician's Office Services - Sickness and Injury		
■ Primary Physician	100% after you pay a $25 Copay per visit[3]	60% after you meet the Annual Deductible
■ Specialist Physician	100% after you pay a $40 Copay per visit[3]	60% after you meet the Annual Deductible
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Spinal Treatment Up to 24 visits per calendar year See Section 6, *Coverage Details*, for limits	100% after you pay a $40 Copay per visit[3]	60% after you meet the Annual Deductible
Substance Use Disorder Services ■ Hospital - Inpatient Stay	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible. Prior notification required through the Mental Health/Substance Use Disorder Administrator.
■ Physician's Office Services	100% after you pay $40 Copay per individual visit[3]; $10 Copay per group visit[3]	60% after you meet the Annual Deductible. Prior notification required through the Mental Health/Substance Use Disorder Administrator.

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