Oregon Teamster Employers Trust: Plan D6

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage Period: 01/01/2015-12/31/2015
Coverage for: Family | **Plan Type:** PPO

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.myregence.com or by calling (866) 240-9580 (Note: the Uniform Glossary can be accessed at: www.cciio.cms.gov.)

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$0** per member per calendar year	You must pay all the costs up to the **deductible** amount before this **plan** begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible.**
Are there other deductibles for specific services?	No.	You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out–of–pocket limit on my expenses?	No.	There's no limit on how much you could pay during a coverage period for your share of the cost of covered services.
What is not included in the out–of–pocket limit?	This plan has no **out–of–pocket limit.**	Not applicable because there's no **out–of–pocket limit** on your expenses.
Is there an overall annual limit on what the plan pays?	Yes. **$1,500**	This plan will pay for covered services only up to this limit during each coverage period, even if your own need is greater. You're responsible for all expenses above this limit. The chart starting on page 2 describes *specific* coverage limits, such as limits on the number of office visits.
Does this plan use a network of providers?	Yes. See www.Regence.com or call 1 (800) 452-8812 for lists of in-network or out-of-network **providers**	If you use an in-network dental **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network dental **provider** may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**
Do I need a referral to see a specialist?	No. You don't need a referral to see a specialist.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 4. See your policy or plan document for additional information about **excluded services.**

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- **Co–insurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for a crown is $500, your **co–insurance** payment of 50% would be $250. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out–of–network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out–of–network dentist charges $200 for an examination and the **allowed amount** is $150, you may have to pay the $50 difference. (This is called **balance billing**.)
- This plan may encourage you to use in–network and out–of–network **providers** by charging you lower **deductibles, co–payments** and **co–insurance** amounts.

Common Dental Event	Services You May Need	Your cost if you use an In–Network Provider	Your cost if you use an Out–of–Network Provider	Limitations & Exceptions
If you have preventive dental services	Cleanings and examinations	25% co-insurance year 1 15% co-insurance year 2 then 5% co-insurance after	25% co-insurance year 1 15% co-insurance year 2 then 5% co-insurance after	Co-insurance resets to year 1 level if Basic Dental Services are not used in a calendar year.
	X–rays	25% co-insurance year 1 15% co-insurance year 2 then 5% co-insurance after	25% co-insurance year 1 15% co-insurance year 2 then 5% co-insurance after	Co-insurance resets to year 1 level if Basic Dental Services are not used in a calendar year.
	Other preventive dental services	25% co-insurance year 1 15% co-insurance year 2 then 5% co-insurance after	25% co-insurance year 1 15% co-insurance year 2 then 5% co-insurance after	Co-insurance resets to year 1 level if Basic Dental Services are not used in a calendar year.
If you need basic dental services	Periodontal services	25% co-insurance year 1 15% co-insurance year 2 then 5% co-insurance after	25% co-insurance year 1 15% co-insurance year 2 then 5% co-insurance after	Co-insurance resets to year 1 level if Basic Dental Services are not used in a calendar year.

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Common Dental Event	Services You May Need	Your cost if you use an In-Network Provider	Your cost if you use an Out-of-Network Provider	Limitations & Exceptions
	Endodontic services	25% co-insurance year 1 15% co-insurance year 2 then 5% co-insurance after	25% co-insurance year 1 15% co-insurance year 2 then 5% co-insurance after	Co-insurance resets to year 1 level if Basic Dental Services are not used in a calendar year.
	Emergency and other basic dental services	25% co-insurance year 1 15% co-insurance year 2 then 5% co-insurance after	25% co-insurance year 1 15% co-insurance year 2 then 5% co-insurance after	Co-insurance resets to year 1 level if Basic Dental Services are not used in a calendar year.
If you need major dental services	Bridges	30% co-insurance	30% co-insurance	No benefits provided for replacements made fewer than 5 years after placement.
	Crowns, inlays and onlays	30% co-insurance	30% co-insurance	No benefits provided for replacements made fewer than 5 years after placement.
	Dentures (full and partial)	30% co-insurance	30% co-insurance	No benefits provided for replacements made fewer than 5 years after placement.
	Implants (endosteal)	Not Covered	Not Covered	——————none——————
If you need orthodontic services	Orthodontia services	70% co-insurance	70% co-insurance	Coverage is limited to orthodontic treatment for a **$1,000** maximum lifetime benefit. No age limit for treatments.
If you need TMJ services	Temporomandibular joint (TMJ) disorder services	Not Covered	Not Covered	——————none——————

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Excluded Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)		
• Cosmetic/reconstructive services and supplies, except congenital anomalies • Duplicate x–rays	• Implants (non–endosteal) • Occlusal treatment • Orthognathic surgery	• Veneers • Tooth transplantation • Facility charges • Gold–foil restorations

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