Comparison Chart
Health Care Benefits for PFSP Full-Time and Part-Time Option 1

Effective January 1, 2017

Medical & Prescription Drug Benefits

	Providence Open Option Plan	Kaiser Permanente HMO	Providence Personal Option Plan
Provider choice	Freedom to choose any qualified provider in or out of the Providence Signature Network; save on out-of-pocket costs if you use Providence Health Plan participating providers	Must use Kaiser providers or Portland Clinic, except in emergency, or if referred outside of the Kaiser network by a Kaiser doctor	Freedom to use any provider in the Providence Signature Network; may use non-participating providers for emergency and urgent services only
How the plan pays benefits	Fixed copays and deductible waived for commonly used in-network services; after you meet any applicable annual deductible, the plan pays a percentage of covered charges: **In-network:** 100% **Out-of-network:** 60% of UCR*	Fixed copays and deductible waived for commonly used in-network services; after you meet any applicable annual deductible, the plan pays up to 100% of covered charges	Fixed copays and deductible waived for commonly used services; after you meet any applicable annual deductible, the plan pays 100% of covered charges
Annual† deductible	$100/individual, $200/family	$100/individual, $300/family	$100/individual, $200/family
Annual† medical out-of-pocket maximum	$1,200/individual, $2,400/family (maximum includes annual deductible, coinsurance and copays for medical and prescription drugs)	$600/individual, $1,200/family (maximum includes annual deductible, coinsurance and copays for medical and prescription drugs)	$1,200/individual, $2,400/family (maximum includes annual deductible, coinsurance and copays for medical only)
Covered services	**What the plan pays**	**What the plan pays**	**What the plan pays**
Physician services			
Office visits (including mental health and chemical dependency), **Office visits to alternative care providers** (chiropractors, naturopaths & acupuncturists)	**In-network:** 100% after you pay a $10 copay per visit** **Out-of-network:** 60%** of UCR* Call Providence to confirm how alternative care benefits will be paid.	100% after you pay a $10 copay per visit	100% after you pay a $10 copay** per visit Call Providence to confirm how alternative care benefits will be paid.
Other procedures in the provider's office such as minor surgery (mole removal, etc.)	**In-network:** 100% after deductible **Out-of-network:** 60% of UCR* after deductible	100% after you pay a $10 copay per visit	100% after deductible
Hospital visits (including mental health and chemical dependency)	**In-network:** 100% after deductible **Out-of-network:** 60% of UCR* after deductible	100% after deductible	100% after deductible
Preventive care services			
Periodic health exams & well-baby care	**In-network:** 100%**, according to frequency schedule*** **Out-of-network:** 60%** of UCR*	100%, according to frequency schedule***	100%**, according to frequency schedule***
Routine immunizations	**In-network:** 100%**, according to frequency schedule*** **Out-of-network:** 60%** of UCR*	100%, according to frequency schedule***	100%**, according to frequency schedule***
Lab and X-ray	**In-network:** 100%** **Out-of-network:** 60% of UCR* after deductible	100%	100%**

* Usual, customary and reasonable charges ** Deductible does not apply
*** Contact your medical plan for schedule details † Based on Calendar year

Effective January 1, 2017

Medical & Prescription Drug Benefits (continued)

	Providence Open Option Plan	Kaiser Permanente HMO	Providence Personal Option Plan
Covered services	**What the plan pays**	**What the plan pays**	**What the plan pays**
Emergency care	**In-network** or **Out-of-network**: 100% after you pay a $100 copay**	**Kaiser or non-Kaiser facility:** 90% after deductible, in or outside the service area; waived if admitted	100% after you pay a $100 copay** at nearest emergency facility
Urgent care	**In-network**: 100% after you pay a $10 copay** per visit; Lab and X-ray 100%** **Out-of-network**: 60%** of UCR* per visit, Lab and X-ray at 60% of UCR*, deductible applies	**Kaiser or Portland Clinic facility:** 100% after you pay a $10 copay, in service area or any facility outside service area	100% after you pay a $10 copay** per visit, Lab and X-ray 100%**
Hospital facility services			
Acute hospital care (including mental health and chemical dependency)	**In-network**: 100% after deductible **Out-of-network**: 60% of UCR* after deductible	100% after deductible	100% after deductible
Maternity services			
Maternity services; pre- and post-natal services/ delivery	**In-network**: Pre-natal: Covered in full Post-natal: 100% after $100 copay** **Out-of-network:** 40% of UCR* after deductible	Pre- and post-natal: Covered in full Delivery: 100% after deductible	Pre-natal: Covered in full Post-natal: 100% after $100 copay**
Hospital services	**In-network**: 100% after deductible **Out-of-network**: 60% of UCR* after deductible	100% after deductible	100% after deductible
Alternative care/chiropractic manipulation and acupuncture			
	$25 copay, $500 calendar year benefit; services must be received from a participating chiropractor or acupuncturist Call Providence to confirm how alternative care benefits will be paid.	Self-referred through the CHP group. **Chiropractic, naturopathy, acupuncture:** 100% after you pay a $10 copay per visit; $1,500 annual benefit maximum for all services combined **Therapeutic massage:** 100% after you pay a $25 copay per visit, up to 12 visits per year	$15 copay, $1,500 calendar year benefit; services must be received from a participating chiropractor or acupuncturist Call Providence to confirm how alternative care benefits will be paid.
Adult hearing aids			
	In-network: 100% after deductible **Out-of-network:** 60% of UCR* after deductible One hearing aid per ear is covered for adults and children every four calendar years. Limitations apply; call Providence for details.	Up to $500 per ear per 3 calendar year period	100% after deductible One hearing aid per ear is covered for adults and children every four calendar years. Limitations apply; call Providence for details.
Vision			
	See Trust Vision Plan Description on the next page	**Covered under Kaiser HMO:** 100% after you pay a $20 copay per exam; 100% up to $250 credit for lenses and frames and/ or contacts, once every 24 months/2 calendar years	**See Trust Vision Plan Description on the next page**

* Usual, customary and reasonable charges ** Deductible does not apply

Effective January 1, 2017

Medical & Prescription Drug Benefits (continued)

	Providence Open Option Plan	Kaiser Permanente HMO	Providence Personal Option Plan
Covered services	**What the plan pays**	**What the plan pays**	**What the plan pays**
Prescription drugs			
Annual prescription out-of-pocket maximum	Prescription expenses apply to the medical out-of-pocket maximum	Prescription expenses apply to the medical out-of-pocket maximum	$1,200/individual, $2,400/family
Retail	**Participating retail pharmacies for up to 30-day supply:** 100% after you pay a $15 copay or 20% coinsurance, whichever is greater for preferred and non-preferred generic and brand-name drugs.‡ Compound drugs: 50% **Preferred retail pharmacies for up to a 90-day supply:** You pay a $45 copay or 20% coinsurance, whichever is greater for preferred and non-preferred generic and brand-name drugs.‡ Compound drugs: 50% **Preferred retail pharmacies include:** Costco, Fred Meyer, Safeway, Walgreens, Kroger/QFC and Albertsons/Sav-on	**Kaiser pharmacies (up to 30-day supply):** 100% after you pay a $5 copay for generic, $10 for brand name **Non-participating pharmacies:** Generally not covered	**Participating CVS Caremark® pharmacies:** 100% after you pay the following copays: **Generic:** 34-day supply: $10 copay 68-day supply: $20 copay 90-day supply: $30 copay **Brand:** 34-day supply: $20 copay 68-day supply: $40 copay 90-day supply: $60 copay‡ **Non-participating pharmacies:** 80% after you pay an annual $50 per person deductible
Mail order (per 90-day supply)	**Mail order supply:** 100% after you pay a $45 copay or 20% coinsurance, whichever is greater for preferred and non-preferred generic and brand-name drugs.‡ Compound drugs: 50% **Mail order pharmacies:** Postal Prescription Services, Walgreens Mail Service and Wellpartner	**Kaiser mail order service:** 100% after you pay a $10 copay for generic, $20 for brand name	**CVS Caremark® mail order service:** 100% after you pay a $20 copay for generic, $40 for brand name‡
Other			
Telehealth	Phone and video consultations, including Providence Express Care Virtual, covered 100%	Phone, email and video consultations covered 100%	Phone and video consultations, including Providence Express Care Virtual, covered 100%

‡ You also pay the difference in cost for brand name drugs if a generic drug is available

Dental Plan Highlights - Administered by Regence BlueCross BlueShield of Oregon

Provider choice	Any licensed dentist*
Annual deductible	None
Covered services	**What the plan pays**
Diagnostic and preventive care (exams, cleaning, X-rays)	100% of UCR**
Basic services (fillings, extractions, minor oral surgery)	80% of UCR**
Restorative services (onlays, crowns)	80% of UCR**
Prosthodontic services (bridges, dentures)	50% of UCR**
Orthodontia	50% of UCR** up to a lifetime maximum benefit of $4,000
Maximum annual benefit	**Plan pays up to $2,500 per individual, per calendar year**

* Regence participating dentists yield a greater discount on services. Call **1-866-240-9580** or visit **regence.com** for a list of providers.
** Usual, customary and reasonable charges

Effective January 1, 2017

Vision Plan Highlights (if you elect a Providence Medical Plan)

	VSP Provider	Other Provider
Benefit	**What the plan pays**	
Well vision exam (every 12 months/adults; every 12 months/child under 17)		
	100%	Up to $70
Frames (every 24 months)		
	Up to $100 allowance and 20% off amount over allowance	Up to $75
Lenses (every 12 months/adults; every 12 months/child under 17)		
Single vision	100%	Up to $50
Lined bifocal	100%	Up to $75
Lined trifocal	100%	Up to $100
Polycarbonate (for dependent children)	100%	N/A
Contacts instead of glasses (every 12 months/adults; every 12 months/child under 17)		
	Up to $60 copay for fitting and evaluation Up to $137 for contacts	Up to $137

Perks and Discounts

Provider	Program	Description	Where to get more details
Providence	Extra Values and Discounts, FitTogether	A discount program offering savings on fitness services, eyewear, alternative care services, hearing aids and free or discounted health education classes.	providencehealthplan.com
Kaiser	CHP Complementary and Alternative Medicine and Healthy Living	Take advantage of a complementary and alternative medicine benefit, including chiropractic services*, naturopathic medicine, massage therapy and acupuncture. This Healthy Living perk also includes discounts on items like lift tickets, weight management programs, gym memberships and more.	kp.org
VSP	Exclusive Member Extras	Get more than $2,500 in savings through special offers, including savings on the latest in eyewear from leading brands.	vsp.com/specialoffers

*Self-referred chiropractic care is provided by the CHP group. Visit chpgroup.com for details.

Note: This chart provides an overview of the benefits available to you. If there is a conflict between this chart and the official plan documents, provisions of the official plan documents will govern how the plans work and how the plans pay benefits. For details, refer to the plan booklets, available on sdtrust.com or from the Trust Office. Providence and Kaiser plan booklets are only available from Customer Service:
Providence **503-574-7500 (Portland)** or **1-800-878-4445**
Kaiser **503-813-2000 (Portland)** or **1-800-813-2000**