



Comparison Chart Health Care Benefits for PFSP, DCU and ATU Early Retirees

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: 80% 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 90% of covered charges	Fixed copays and deductible waived for commonly used services; after you meet any applicable annual deductible, the plan pays 90% of covered charges
Annual [†] deductible	\$100/individual, \$200/family	\$100/individual, \$300/family	\$100/individual, \$200/family
Annual [†] medical out-of-pocket maximum	\$2,200/individual, \$4,400/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 and prescription drugs)	\$2,200/individual, \$4,400/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 \$20 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 \$20 copay per visit	100% after you pay a \$20 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: 80% after deductible Out-of-network: 60% of UCR* after deductible	100% after you pay a \$20 copay per visit	90% after deductible
Hospital visits (including mental health and chemical dependency)	In-network: 80% after deductible Out-of-network: 60% of UCR* after deductible	90% after deductible	90% 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***
Outpatient services			
Lab and X-ray	In-network: 80%** Out-of-network: 60% of UCR* after deductible	100%	90%**

* Usual, customary and reasonable charges

** Deductible does not apply

*** Contact your medical plan for schedule

[†] 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 services			
Emergency or urgent care from participating providers	Emergency room: In-network or Out-of-network: 100% after you pay a \$100 copay** Urgent care: In-network: 100% after you pay a \$20 copay** per visit; Lab and X-ray 80%** Out-of-network: 60% of UCR* per visit deductible waived, Lab and X-ray 60% of UCR*, deductible applies	Emergency room: Kaiser or non-Kaiser facility: 90% after deductible in or outside the service area; waived if admitted Urgent care: Kaiser facility: Plan pays 100% after you pay a \$20 copay, in service area or any facility outside service area	Emergency room: 100% after you pay a \$100 copay** at nearest emergency facility Urgent care: 100% after you pay a \$20 copay**, Lab and X-ray 90%
Hospital facility service			
Acute hospital care (including mental health and chemical dependency)	In-network: 80% after deductible Out-of-network: 60% of UCR* after deductible	90% after deductible	90% after deductible
Skilled nursing facility	In-network: 80% after deductible Out-of-network: 60% of UCR* after deductible; up to 60 days per calendar year	90% after deductible, up to 100 days per calendar year	90% up to 60 days per calendar year after deductible
Durable medical equipment	In-network: 80% after deductible Out-of-network: 60% of UCR* after deductible	80%	90% after deductible (deductible waived for diabetic supplies)
Alternative care/spinal 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.	Not covered	\$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.
Vision			
	Not covered; you may be eligible to enroll in Trust Vision Plan on a self-pay basis	100% after a \$20 copay for exam; 100% up to \$100 credit for lenses and frames once every 24 months	Not covered; you may be eligible to enroll in Trust Vision Plan on a self-pay basis
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	\$2,200/individual, \$4,400/family
Retail	Participating retail pharmacies for up to 30-day supply: 100% after you pay a \$15 copay or 50% coinsurance, whichever is greater for preferred and non-preferred generic and brand-name drugs.† Compound drugs: 50%	Kaiser pharmacies (up to 30-day supply): You pay 50% of cost of drug, up to \$50 maximum copay	Participating CVS Caremark® pharmacies (per 30-day supply): You pay 50% of cost of drug, up to \$50 for generic or brand†
Mail Order (per 90-day supply)	Mail order and preferred retail: 100% after you pay a \$45 copay or 50% 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 Preferred retail pharmacies include: Costco, Fred Meyer, Safeway, Walgreens, Kroger/QFC and Albertsons/Sav-on	Kaiser mail order service: You pay 50% of cost of drug, up to \$100 maximum copay	CVS Caremark® mail order service: You pay 50% of cost of drug, up to \$150 for generic or brand†

* Usual, customary and reasonable charges

** Deductible does not apply

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

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Covered services	What the plan pays	What the plan pays	What the plan pays
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%

Trust Dental/Vision Options on a Self-Pay Basis

You pay the full cost of the Early Retiree Trust Dental/Vision coverage. For details on your benefit costs, refer to Early Retiree rate sheet.

Dental - Administered by Regence BlueCross BlueShield of Oregon

	Basic Dental	Buy-Up Dental
Provider choice	Any licensed dentist*	Any licensed dentist*
Annual individual deductible	\$50	None
Maximum Annual Benefit	Plan pays up to \$1,200 per individual per calendar year	Plan pays up to \$1,750 per individual per calendar year
Covered services	What the plan pays	What the plan pays
Diagnostic and preventive care (exams, cleaning, X-rays)	80% of UCR** after deductible	100% of UCR**
Basic services (fillings, extractions, minor oral surgery)	80% of UCR** after deductible	80% of UCR**
Restorative services (onlays, crowns)	50% of UCR** after deductible	80% of UCR**
Prosthetic services (bridges, dentures)	50% of UCR** after deductible	50% of UCR**
Orthodontia	Not covered	50% of UCR**, up to \$1,250 lifetime benefit maximum per person

* 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

Basic Vision Plan - Administered by VSP

	VSP Provider	Other Provider
Benefit	What the plan pays	
Well vision exam (every 24 months)	100% after \$25 copay	Up to \$45
Frames (every 24 months)	After your \$25 copay, up to \$120 allowance and 20% off amount over allowance	Up to \$47
Lenses (every 24 months)		
Single vision	100% after \$25 copay	Up to \$45
Lined bifocal	100% after \$25 copay	Up to \$65
Lined trifocal	100% after \$25 copay	Up to \$85
Polycarbonate (for dependent children)	100% after \$25 copay	N/A
Contacts instead of glasses (every 24 months)		
	Up to \$60 copay for fitting and evaluation Up to \$105 for contacts	Up to \$105

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Buy-Up Vision Plan - Administered by VSP

	VSP Provider	Other Provider
Benefit	What the plan pays	
Well vision exam (every 24 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 24 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 24 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, 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

