Health and Welfare Trust
School District No. 1

Full-Time and Option 1 for Part-Time PAT Active Comparison Chart

Effective January 1, 2018

Option 1—PAT Actives Healthcare Benefits Comparison Chart

Medical, Prescription, Dental, Vision, Basic Life and Accidental Death & Dismemberment Insurance Benefits

	Trust Preferred Provider Plan (Regence)	Kaiser Permanente HMO	Providence Personal Option Plan
Provider choice	Choose a Regence preferred provider, a Regence participating provider, or a non-Regence participating provider. Benefits vary based on which category you choose. Find a list of providers at **regence.com**	Must use Kaiser or Portland Clinic providers, except in cases of emergency or when referred outside the network by Kaiser	Freedom to use any provider in the Providence Signature Network. May use out-of-network providers for emergency and urgent services only
How the plan pays benefits	After you meet the annual deductible, plan pays a percentage of covered charges: **Preferred**: 80% **Non-preferred:** 70% of allowable charges	Most covered services paid in full after applicable copayment	Office visits are covered at 100% after you pay a $10 copayment; most other covered services are paid at 90%
Annual deductible*	$100/individual, $300/family	None	None
Annual out-of-pocket maximum*	$1,000/individual, $2,000/family; after the annual deductible	$600/individual, $1,200/family	$1,200/individual, $2,400/family
Covered services	**What the plan pays**	**What the plan pays**	**What the plan pays**
Physician services			
Office visits (including mental health and chemical dependency [MH/CD])	**Preferred:** 80% after deductible **Participating & Non-Participating:** 70% after deductible (MH/CD paid at 80%/80%/70%)	100% after you pay a $5 copayment per visit	100% after you pay a $10 copayment per visit
Hospital visits (including mental health and chemical dependency [MH/CD])	**Preferred:** 80% after deductible **Participating and Non-Participating:** 70% after deductible (MH/CD paid at 80%/80%/70%)	100%	90%
Preventive care services			
Periodic health exams and well-baby care	**Preferred and Participating:** 100%, according to frequency schedule** **Non-Participating:** 70% of allowable charges after deductible	100%, according to frequency schedule**	100%, according to frequency schedule**
Lab and X-ray	**Preferred:** 80% after deductible **Participating and Non-Participating:** 70% of allowable charges after deductible	100%	90%
Emergency care	**Any Provider:** 100% after you pay a $100 copayment per visit, deductible waived; copayment waived if admitted	**Kaiser or non-Kaiser facility:** 100% after you pay a $25 copayment, in or outside the service area; waived if admitted	100% after you pay a $100 copayment at nearest emergency facility
Urgent care	**Preferred:** 80% after deductible **Participating and Non-Participating:** 70% of allowable charges after deductible	When inside the service area, must use Kaiser or Portland Clinic facility: 100% after you pay a $5 office visit copayment	100% after you pay a $10 copayment per visit. Lab and X-ray 90%

* Based on Calendar year
** Contact your medical plan for schedule
‡ You may also pay the difference in cost for brand name drugs if a generic drug is available

Option 1	Trust Preferred Provider Plan (Regence)	Kaiser Permanente HMO	Providence Personal Option Plan
Covered services	**What the plan pays**	**What the plan pays**	**What the plan pays**
Hospital facility services			
Acute hospital care (including mental health and chemical dependency	**Preferred:** 80% after deductible **Participating and Non-Participating:** 70% of allowable charges after deductible (MH/CD paid at 80%/80%/70%)	100%	90%
Ambulatory Surgery Center Benefit	90% of allowable charges after deductible	N/A	90%
Maternity services			
Pre- and post-natal care	**Preferred:** 80% after deductible **Non-preferred and Non-Participating:** 70% of allowable charges after deductible	100%	Pre-natal: Covered in full Post-natal: 90%
Delivery and hospital services	**Preferred:** 80% after deductible **Non-preferred and Non-Participating:** 70% of allowable charges after deductible	100%	90%
Alternative care /chiropractic manipulation and acupuncture			
	Chiropractic, naturopathy, acupuncture: **Preferred, Non-preferred and Non-Participating:** 80% after deductible	Self-referred through the CHP group. Chiropractic, naturopathy, acupuncture: 100% after you pay a $10 copayment per visit; $1,500 annual benefit maximum for all services combined Therapeutic massage: 100% after you pay a $25 copayment per visit, up to 12 visits per year	Chiropractic only: 100% after you pay a $10 copayment per visit; up to 20 visits per calendar year
Prescription drugs			
Prescription Plan	Trust Prescription Drug Plan through CVS/Caremark	Kaiser Permanente HMO Prescription Drug Plan	Trust Prescription Drug Plan through CVS/Caremark
Annual prescription out-of-pocket maximum	$2,200/individual, $4,400/family	Prescription expenses apply to the medical out-of-pocket maximum	$2,200/individual, $4,400/family
Outpatient Retail ‡	**Participating CVS/Caremark pharmacies:** 100% after you pay the following copays: **Generic:** 30-day supply: $10 copay 60-day supply: $20 copay 90-day supply: $30 copay **Brand:** 30-day supply: $20 copay 60-day supply: $40 copay 90-day supply: $60 copay **Non-participating pharmacies:** Pay out of pocket and submit to CVS for reimbursement	**Kaiser pharmacies (up to 30-day supply):** 100% after you pay a $5 copayment for generic, $10 for brand name **Non-participating pharmacies:** Generally not covered	**Participating CVS/Caremark pharmacies:** 100% after you pay the following copays: **Generic:** 30-day supply: $10 copay 60-day supply: $20 copay 90-day supply: $30 copay **Brand:** 30-day supply: $20 copay 60-day supply: $40 copay 90-day supply: $60 copay **Non-participating pharmacies:** Pay out of pocket and submit to CVS for reimbursement
Outpatient Mail order ‡ (per 90-day supply)	**CVS/Caremark mail order service:** $20 copay for generic, $40 copay for brand name	**Kaiser mail order service:** 100% after you pay a $5 copay for generic, $10 for brand name	**CVS/Caremark mail order service:** $20 copay for generic, $40 copay for brand name

* Based on Calendar year
** Contact your medical plan for schedule
‡ You may also pay the difference in cost for brand name drugs if a generic drug is available

Other			
Virtual Visits	MDLIVE	Phone, email and video consultations covered 100%	Phone and video consultations, including Providence Express Care Virtual, covered 100%

Perks and Discounts			
Provider	**Program**	**Description**	**For details go to:**
Regence	Advantages	A discount program offering savings on health-related products and services, including discounts on eyewear and laser vision correction services, hearing aids, dental services and fitness products.	**regence.com**
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. *Self-referred chiropractic care is provided by the CHP group. Visit **chpgroup.com** for details.	**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**

Trust 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 $1,250
Maximum annual benefit	Plan pays up to $1,750 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

Option 1—Vision Plan Highlights

	Trust Preferred Provider (Regence)—Trust Vision Plan*	Kaiser Permanente HMO	Providence Personal Option Plan—Trust Vision Plan*
Covered services	**What the plan pays**	**What the plan pays**	**What the plan pays**
Well vision exam	Every 12 months for children up to age 17; every 24 months over age 17 VSP Provider: 100% Other Provider: Up to $70	Every 12 months, adults and children 100% after $20 copay per exam	Every 12 months for children up to age 17; every 24 months over age 17 VSP Provider: 100% Other Provider: Up to $70
Frames	Every 24 months VSP Provider: Up to $100 allowance and 20% off amount over allowance Other Provider: Up to $75	100% up to $250 credit , once every 24 months / 2 calendar years	Every 24 months VSP Provider: Up to $100 allowance and 20% off amount over allowance Other Provider: Up to $75
Lenses	Every 12 months for children under age 17; every 24 months over age 17 VSP Provider: Single Vision: 100% Lined Bifocal: 100% Lined trifocal: 100% Polycarbonate (for dependent children): 100% Other Provider: Single Vision: Up to $50 Lined Bifocal: Up to $75 Lined trifocal: Up to $100 Polycarbonate (for dependent children): N/A	100% up to $250 credit, once every 24 months / 2 calendar years	Every 12 months for children under age 17; every 24 months over age 17 VSP Provider: Single Vision: 100% Lined Bifocal: 100% Lined trifocal: 100% Polycarbonate (for dependent children): 100% Other Provider: Single Vision: Up to $50 Lined Bifocal: Up to $75 Lined trifocal: Up to $100 Polycarbonate (for dependent children): N/A
Contacts instead of glasses	Every 24 months/adults; every 12 months/child under 17 VSP Provider: Up to $60 copay for fitting and evaluation; up to $137 for contacts Other Provider: Up to $137	Every 24 months/ 2 calendar years	Every 24 months/adults; every 12 months/child under 17 VSP Provider: Up to $60 copay for fitting and evaluation; up to $137 for contacts Other Provider: Up to $137

* Administered by VSP

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 **1-503-574-7500 (Portland)** or **1-800-878-4445**

Kaiser **1-503-813-2000 (Portland)** or **1-800-813-2000**

Regence **1-866-240-9580** Customer Service

Regence **1-800-810-BLUE (2583)** for BlueCard questions (out of area services)