Health and Welfare Trust
School District No. 1

Full-Time and Option 1 for Part-Time PFSP Actives Comparison Chart

Effective January 1, 2018

Full-Time and Option 1 for Part-Time— PFSP Actives Healthcare Benefits Comparison Chart

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

Full-Time and Option 1 for Part-Time	Providence Option Advantage 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 only)	$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

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Full-Time and Option 1 for Part-Time	Providence Option Advantage 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:** 60% 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.
Hearing benefits			
	Routine hearing exams and tests: **In-network:** $10 copay **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/ear per 3 calendar year period	100% after deductible $10 copay for routine hearing exams and tests. One hearing aid per ear is covered for adults and children every four calendar years. Limitations apply; call Providence for details.

* Usual, customary and reasonable charges

** Deductible does not apply

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† Based on Calendar year

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

Full-Time and Option 1 for Part-Time	Providence Option Advantage Plan	Kaiser Permanente HMO	Providence Personal Option Plan
Covered services	**What the plan pays**	**What the plan pays**	**What the plan pays**
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	$1,200/individual, $2,400/family	Prescription expenses apply to the medical out-of-pocket maximum	$1,200/individual, $2,400/family
Outpatient Retail ‡	**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:** Pay out of pocket and submit to CVS for reimbursement	**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:** Pay out of pocket and submit to CVS for reimbursement
Mail order ‡ (per 90-day supply)	**CVS/Caremark mail order service:** $20 copay for generic, $40 for brand name	**Kaiser mail order service:** 100% after you pay a $10 copay for generic, $20 for brand name	**CVS/Caremark mail order service:** $20 copay for generic, $40 for brand name
Other			
Virtual Visits	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%

Perks and Discounts

Provider	Program	Description	For details go to:
Providence Plans	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

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

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 $4,000/person
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

Vision Plan Highlights

	Providence Option Advantage Plan—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, adults and children VSP Provider: 100% Other Provider: Up to $70	Every 12 months, adults and children 100% after $20 copay per exam	Every 12 months, adults and children VSP Provider: 100% Other Provider: Up to $70
Frames	VSP Provider: Up to $100 allowance and 20% off amount over allowance, every 24 months Other Provider: Up to $75	100% up to $250 credit , once every 24 months / 2 calendar years	VSP Provider: Up to $100 allowance and 20% off amount over allowance, every 24 months Other Provider: Up to $75
Lenses	Every 12 months, adults and children VSP Provider: Single Vision: 100% Lined Bifocal: 100% Lined trifocal: 100% Polycarbonate lenses for dependent children: 100% 35%–40% average savings on all non-covered lens options Other Provider: Single Vision: Up to $50 Lined Bifocal: Up to $75 Lined trifocal: Up to $100 Progressive: Up to $100	100% up to $250 credit, once every 24 months / 2 calendar years	Every 12 months, adults and children VSP Provider: Single Vision: 100% Lined Bifocal: 100% Lined trifocal: 100% Polycarbonate lenses for dependent children: 100% 35%–40% average savings on all non-covered lens options Other Provider: Single Vision: Up to $50 Lined Bifocal: Up to $75 Lined trifocal: Up to $100 Progressive: Up to $100
Contacts instead of glasses	Every 12 months, adults and children VSP Provider: A 15% discount is available for fitting and evaluation and no more than $60 copay; up to $137 for contacts Other Provider: Up to $137	Every 24 months/ 2 calendar years	Every 12 months, adults and children VSP Provider: A 15% discount is available for fitting and evaluation and no more than $60 copay; 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**