Health and Welfare Trust
School District No. 1

PFSP, DCU and ATU Early Retirees Comparison Chart

Effective January 1, 2018

PFSP, DCU and ATU Early Retirees Healthcare Benefits Comparison Chart

Medical and Prescription Drug Benefits

	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**: 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 only)	$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 details
† Based on Calendar year ‡ You also pay the difference in cost for brand name drugs if a generic drug is available

	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 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 services			
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; up to 60 days per calendar year **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 (deductible waived for diabetic supplies) **Out-of-network:** 60% of UCR* after deductible	80%	90% after deductible (deductible waived for diabetic supplies)
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.	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 (see page 9)	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 (see page 9)
Prescription drugs			
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
Retail	**Participating CVS/Caremark pharmacies (per 30-day supply):** You pay 50% of cost of drug, up to $50 for generic or brand‡	**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)	**CVS/Caremark mail order service:** You pay 50% of cost of drug, up to $150 for generic or brand‡	**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 *** Contact your medical plan for schedule details
† Based on Calendar year ‡ You also pay the difference in cost for brand name drugs if a generic drug is available

	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**
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%
Hearing Benefits	**In-network:** 80% after deductible **Out-of-network:** 60% of UCR* after deductible $20 copay for routine hearing exams and tests in network; 60% of UCR* out-of-network. 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	90% after deductible $20 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.

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
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 Options on a Self-Pay Basis

Administered by Regence BlueCross BlueShield of Oregon

You pay the full cost of the Early Retiree Trust Dental coverage. For details on your benefit costs see page 5.

	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**	
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**
Prosthodontic 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

Trust Vision Options on a Self-Pay Basis

Administered by VSP

You pay the full cost of the Early Retiree Trust Vision coverage. For details on your benefit costs see page 5.

Basic Vision Plan	VSP Provider	Other Provider
Benefit	**What the plan pays**	**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

Buy-up Vision Plan	VSP Provider	Other Provider
Benefit	**What the plan pays**	**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

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**