Harrison Electrical Workers Trust Fund
2020 Medical Options

All information contained in this benefit comparison is in summary and does not fully describe your benefit coverage. For specific information about your medical options, refer to your benefits booklet, or you may obtain a benefits packet for the plan of your choice from the Trust Office. You may also contact the health plan's Customer Service for further assistance. If there is any conflict between this summary and the SPD, the SPD prevails.

Medical Plan Feature	Trust Self-Funded Plan	Kaiser Permanente HMO	Providence Option Advantages
Provider Choice	Any provider. In Oregon and SW Wash.: Providence PPO **www.providence.org/health_plans** **Click on Providence PPO** Outside area: Multiplan http://myhealthfirst.com	Except for emergencies, you must receive care from Kaiser Permanente and affiliated providers. www.kp.org	Refer to the Providence Provider Directory Provider list can be viewed at **www.providence.org/health_plans** **(Click on Signature Network option)**
Coverage Area	Anywhere with Reimbursement at 60% of UCR (Preferred providers reimbursed at 80%)	You must live or work within the Kaiser Service Area	**OREGON:** all counties. **WASHINGTON:** Clark, Skamania and Klickitat counties
Annual Deductible	$500 per person, $1,000 per family (2 or more persons)	$500 per person/$1,500 per family (3 or more persons) (office visits not subject to deductible)	$500 per person, up to $1,000 (2 or more persons). (Waived for many outpatient services from participating providers)
Medical Out-of-Pocket Maximum (includes deductible) (Coinsurance)	In-Network: $3,000 per person, $6,000 per family (2 or more persons) Out-of-Network: $3,000 per person, $6,000 per family (2 or more persons)	$6,000 per person/$12,000 per family (2 or more persons) (not all copays apply to this limit)	$6,000 per person, up to $12,000 (2 or more persons). (Some services do not apply to maximums) Many services require prior authorization If you do not obtain prior authorization for services from a non-participating provider, a 50% penalty, not to exceed $2,500 will apply to each covered service
Rx Out-of-Pocket Maximum	$3,000 per person, $6,000 per family (2 or more persons)	No separate out-of-pocket maximum for Rx	No separate out-of-pocket maximum for Rx

Covered Services	Plan Pays	Plan Pays	Plan Pays	
			IN-NETWORK	OUT-OF-NETWORK
Doctor's Office Visits	80% In-Network Preferred Providers 60% UCR* Out-of-Network Providers	100% after you pay $20 co-pay per visit for primary doctor/ $30 co-pay per visit for specialist	100% after $20 co-pay per visit (Deductible does not apply)	60% UCR* After Deductible
Hospital Services	80% In-Network Preferred Providers 60% UCR* Out-of-Network Providers	80%	80% (including maternity and newborn nursery care) (Deductible does not apply to newborn nursery care)	60% UCR* After Deductible

***Benefits paid at UCR (Usual, customary and reasonable charges)**

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Medical Plan Feature	Trust Self-Funded Plan	Kaiser Permanente HMO	Providence Core Advantages	
Covered Services	Plan Pays	Plan Pays	Plan Pays	
			IN-NETWORK	OUT-OF-NETWORK
Hospital Services	80% In-Network Preferred Providers 60% UCR* Out-of-Network Providers	80%	80% (including maternity and newborn nursery care) (Deductible does not apply to newborn nursery care)	60% UCR* After Deductible
Maternity - Outpatient	80% In-Network Preferred Providers 60% UCR* Out-of-Network Providers	100% after $20 co-pay per visit	80%	60% UCR* After Deductible
Emergency Room Care (Benefits may be reduced for non emergency treatment)	80% UCR* after deductible and $250 copay Co-pay waived if admitted	80%	100% after $300/$600 deductible and $250 co-pay (Copay waived if admitted within 24 hours)	100% after deductible and $250 co-pay (Copay waived if admitted within 24 hours)
Preventive Care	In Network Providers: 100% (deductible does not apply) Out-of-Network Providers: Not covered	100%	100% after you pay $20 office visit co-pay (deductible does not apply)	60% UCR* After Deductible
Chiropractic Manipulation and Acupuncture Services	80% In-Network Preferred Providers 60% UCR* Out-of-Network Providers (26 visits per calendar year)	Not covered unless by authorized Kaiser referral (however, discounts available from participating providers)	Not a covered service (however service discounts available from participating providers)	Not Covered
X-ray and Lab	80% In-Network Preferred Providers 60% UCR* Out-of-Network Providers	100% after $20 co-pay per visit (deductible does not apply)	80% (Deductible does not apply)	60% UCR* After Deductible
Hi-Tech Imaging Services (PET, CT, MRI, etc)	80% In-Network Preferred Providers 60% UCR* Out-of-Network Providers	100% after $100 co-pay per visit (deductible does not apply)	80%	60% UCR* After Deductible

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Medical Plan Feature	Trust Self-Funded Plan	Kaiser Permanente HMO	Providence Core Advantages
Covered Services	**Plan Pays**	**Plan Pays**	**Plan Pays**
Prescription Drugs **Refer to Plan Booklet for full benefit outline.**	**Providence participating pharmacies (up to 30 day supply)**: Generic: $15 copay Preferred Brand: $35 copay Non-Preferred Brand: $70 copay Specialty: $150 copay **Providence Mail Order (90-day supply):** Generic: $30 copay Preferred Brand: $70 copay Non-Preferred Brand: $140 copay Prescriptions by Mail: You may obtain a 90-day supply (two copayments will apply) Costco Home Delivery, Postal Prescription Services or 90-day supply at Fred Meyer, Walgreens or Providence pharmacies.	Kaiser Formulary Rx; (non-formulary medications are not covered): Generic: $15 copay (up to 30-day supply) Preferred Brand: $30 copay (up to 30-day supply) Non-Preferred Brand: $50 copay (up to 30-day supply) Specialty medications: $50 copay up to 30-day supply Mail Order for maintenance medications: 90-day supply for 2 copays	Preferred Generic: $10 copay for a 30-day supply purchased at a participating retail pharmacy Non-Preferred Generic Drugs: $15 copay for a 30-day supply purchased at a participating retail pharmacy Preferred Brand-Name: $30 copay for a 30-day supply Non-Preferred Brand-Name: $60 copay for a 30-day supply purchased at a participating retail pharmacy Specialty and Compound Medications: 50% coinsurance up to a $200 retail and $200 mail order Prescriptions by Mail: You may obtain a 90-day supply (two copayments will apply) of each maintenance drug through Costco Home Delivery, Postal Prescription Services or 90-day at Fred Meyer, Walgreens or Providence pharmacies. Use of Non-Participating Pharmacies: Reimbursement subject to review

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Vision Benefits provided by the Trust through Vision Service Plan. (Except Kaiser participants) **Refer to Plan Booklet for full benefit description.**	In-Network VSP Provider: Exam: You pay $15 copayment Glasses: You pay $25 copayment and any non-covered services Frames are covered once every 24 months with a $150 allowance and 20% off out-of-pocket above that amount. Lenses are covered every 12 months (single vision, lined bifocal or lined trifocal).	Kaiser Permanente Plan provider: Exam: You pay $20 copayment per visit, no limit on number of visits. Glasses or contact lenses: You pay balance after a credit of $150 once every two years	In-Network VSP Provider: Exam: You pay $15 copayment Glasses: You pay $25 copayment and any non-covered services Frames are covered once every 24-months with a $150 allowance and 20% off out-of-pocket above that amount. Lenses are covered every 12 months (single vision, lined bifocal or lined trifocal).

Benefit Questions?		
Harrison Trust Office:	(503) 224-0048, ext. 1618	(800) 547-4457, ext. 1679
Kaiser Permanente Membership Services:	(503) 813-2000	(800) 813-2000 (Refer to Group #2454)
Providence Health Plan:	(503) 574-7500	(800) 878-4445 (Refer to Group #105122)

***Benefits paid at UCR (Usual, customary and reasonable charges)**

Harrison Electrical Workers Trust Fund
2020 Active Plan Dental Options

The following chart shows key features of your dental options. For more information about your dental options refer to your benefit booklet, or you may obtain a Kaiser or Willamette dental benefits packet from the Trust Office. If there is any conflict between this summary and the SPD, the SPD prevails.

Dental Plan Feature	Trust Self-Funded Dental Plan	Kaiser Dental	Willamette Dental
Provider Choice	Any Provider	Kaiser Providers	Willamette Dental Providers
Coverage Area	Anywhere	You must live or work within the Kaiser Service Area	Anywhere in Willamette Dental Service Area (Western & Central Oregon, Washington, Idaho)
Annual Deductible	$25 per person	None	None
Annual Maximum Benefit	$1,500 per person	$1,500 per person	No annual maximum
Covered Services	**Plan Pays**	**Plan Pays**	**Plan Pays**
Preventive Care			
Routine office Visits	80% UCR*	100% after $10 copayment per visit	100% after $10 copayment per visit
Oral exam	70% UCR*	100% after $10 copayment per visit	100% after $10 copayment per visit
Cleaning	80% UCR*	100% after $10 copayment per visit	100% after $10 copayment per visit
X-rays	70% UCR*	100% after $10 copayment per visit	100% after $10 copayment per visit
Basic Services			
Routine fillings and simple extractions.	70% UCR*	80%, after $10 copayment per visit	100% after $10 copayment per visit
Oral Surgery	70% UCR*	80%, after $10 copayment per visit	Participant Pays: $100
Root Canal	70% UCR*	80%, after $10 copayment per visit	Participant pays: $75-$125, depending on tooth
Major Services: (Crowns, inlays, onlays, bridges, dentures)	50% UCR*	50% after $10 copayment per visit	Participant Pays: Crowns: $150 Upper or Lower Denture: $200 Bridge (per tooth): $150
Orthodontia Lifetime maximum per person	80% UCR* $2,000	80%, after $10 copayment per visit $2,000	Participant Pays: $1,500 for Comprehensive Orthodontia.

* Usual, customary and reasonable

This is just a summary of benefits. Please refer to Trust Plan Booklet or Carrier Benefit Booklets for a complete description.

PMB #116 • 5331 SW Macadam Avenue • Suite 258, Portland, OR 97239
(503) 224-0048 (800) 547-4457 Fax (503) 228-0149