

# Harrison Electrical Workers Trust Fund

## 2010 Retired Plan 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.

Medical Plan Feature	Trust Self-Funded Plan	Kaiser Permanente HMO	Providence Open Option	
Provider Choice	Any provider. In Oregon and SW Wash.: Providence PPO <a href="http://www.providence.org/health_plans">www.providence.org/health_plans</a> <b>Click on Providence PPO</b> Outside area: Multiplan <a href="http://ppo.multiplan.com">http://ppo.multiplan.com</a>	Except for emergencies, you must receive care from Kaiser Permanente and affiliated providers.	Refer to the Providence Provider Directory Provider list can be viewed at <a href="http://www.providence.org/health_plans">www.providence.org/health_plans</a> <b>(Click on Open Option)</b>	
Coverage Area	Anywhere Reimbursement at 70% of UCR (Preferred providers reimbursed at 80%)	You must live or work within the Kaiser Service Area	<b>OREGON:</b> all counties <b>except</b> Baker, Curry, Lake, Malheur, Morrow, Union, Wallowa and parts of Klamath and Tillamook countries. <b>WASHINGTON:</b> all counties <b>except</b> Asotin.	
Annual Deductible	\$250 per person, up to \$750 per family	\$100 per person/\$300 per family (office visits not subject to deductible)	\$250 per person, up to \$750 per family (Waived for many outpatient services from participating providers)	
Out of Pocket Maximum (Coinsurance)	\$2,000 per person, up to \$6,000 per family (excluding deductible and Rx)	\$2,000 per person/\$6,000 per family (not all copays apply to this limit)	\$2,000 per person, up to \$6,000 per family. (Deductibles and some services do not apply to maximums) Many services require prior authorization, or 50% penalty of UCR charges (Up to \$2,500 per occurrence) will apply	
Lifetime Maximum Benefit	\$2,000,000	\$2,000,000	\$2,000,000	
Covered Services	Plan Pays	Plan Pays	Plan Pays	
			IN-PLAN	OUT-OF-PLAN
Doctor's Office Visits	70% UCR* (80% Preferred Providers)	100% after you pay \$15 co-pay per visit for primary doctor/ \$25 co-pay per visit for specialist	100% after \$15 co-pay per visit (Deductible does not apply)	60% UCR* (Deductible does not apply)
Hospital Services	70% UCR* (80% Preferred Providers)	80% after the \$100/\$300 deductible per member/family	80% (including maternity and newborn nursery care) (Deductible does not apply to newborn nursery care)	60% UCR*
Maternity - Outpatient	70% UCR* (80% Preferred Providers)	100% after \$15 co-pay per visit	\$150 co-pay (no deductible) for pre/post-natal visits & delivery	60% UCR*
Emergency Room Care (Benefits may be reduced for non emergency treatment)	70% UCR* (80% Preferred Providers)	80% after the \$100/\$300 deductible per member/family	100% after \$125 co-pay (Copoly waived if admitted within 24 hours) (Deductible does not apply)	100% after \$125 co-pay (Copoly waived if admitted within 24 hours) (Deductible does not apply)
Preventive Care	Annual mammogram, pelvic exam, breast exam, pap smears, and prostate exam subject to deductible and coinsurance 70% UCR* (80% Preferred Providers)	100% after you pay \$15 office visit co-pay per visit.	100% after you pay \$15 office visit co-pay with Personal/Physician/Provider only) Deductible does not apply	60% UCR*

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Medical Plan Feature	Trust Self-Funded Plan	Kaiser Permanente HMO	Providence Open Option	
Well Baby Care	70% UCR* (80% Preferred Providers) ages 0-3 years	No charge for ages 0-2.	100% after \$15 copayment per visit	Not Covered
Chiropractic Services and Alternative Care	70% UCR* (80% Preferred 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, Lab and Special Diagnostic Procedures	70% UCR* (80% Preferred Providers)	100% after \$20 co-pay per visit	80% (Deductible does not apply)	60% UCR*
Prescription Drugs <b>Refer to Plan Booklet for full benefit outline.</b>	<b>Kroger Prescription Plans participating pharmacies:</b> Generic: \$10 copay (up to 30-day supply) Brand: \$30 copay or 20% of cost of drug if greater, maximum \$50 (up to 30-day supply) <b>Postal Prescription Service:</b> Generic: \$10 copay (up to 90-day supply) Brand: \$60 or 20% if greater, maximum \$100 copay (up to 90-day supply)	Kaiser Formulary Rx; (non-formulary medications are not covered): Generic: \$15 copay (up to 30 day supply) Brand: \$30 copay (up to 30 day supply)  Mail Order for maintenance medications: 90-day supply for 2 copays	Generic: \$15 copay for a 30-day supply purchased at a participating retail pharmacy Brand-name: \$30 copay for up to a 30-day supply purchased at a participating retail pharmacy ( <b>when a generic equivalent is not available</b> ) Compounded prescription drugs: 50% copayment for up to a 30-day supply purchased at a participating retail pharmacy  Prescriptions by Mail: You may obtain a 90-day supply (three copayments will apply) of each maintenance drug through Wellpartner, Inc, or Walgreens Healthcare Plus or 90-day at Fred Meyer, Walgreens or Providence pharmacies.  Use of Non-Participating Pharmacies: Reimbursement subject to review	
Vision Benefits provided by the Trust through Vision Service Plan. (Except Kaiser participants) <b>Refer to Plan Booklet for full benefit outline.</b>	At a 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 \$130 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 \$15 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	At a 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 \$130 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  
Kaiser Permanente Membership Services: (503) 813-2000  
Providence Health Plan: (503) 574-7500

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

(800) 547-4457, ext. 1618  
(800) 813-2000 (Refer to Group #2454)  
(800) 878-4445 (Refer to Group 105122)