Harrison Electrical Workers Trust Fund
2022 Medical Options

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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 **www.multiplan.com/webscenter/portal/ProviderSearch**	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)	60% UCR* After Deductible

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

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			(Deductible does not apply to newborn nursery care)	
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	80% In-Network Preferred Providers 60% UCR* Out-of-Network Providers (26 visits per calendar year)	Physician referred chiropractic are no longer covered.	20 chiropractor visits per member per calendar year.	Not Covered
Acupuncture Services and Massage Therapy	80% In-Network Preferred Providers 60% UCR* Out-of-Network Providers (Combination of 26 visits per calendar year total)	Physician referred acupuncture are no longer covered.	12 acupuncture visits per member per calendar year.	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

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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

Medical Plan Feature **Covered Services**	**Trust Self-Funded Plan** **Plan Pays**	**Kaiser Permanente HMO** **Plan Pays**	**Providence Core Advantages** **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 $25 copayment Glasses: You pay $25 copayment and any non-covered services Frames are covered once every 12 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. 1679	(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)

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