



THE TRUST

School District No. 1
Health and Welfare Trust

PAT Part-Time Option 2 Medical & Prescription Drug Benefits

Effective February 1, 2011

Medical & Prescription Drug Benefits

	Trust Indemnity Plan	Kaiser Permanente HMO	Providence Personal Option (EPO) Plan
Provider choice	May use any covered provider; use Providence Preferred (PPO) or Beech Street network providers for highest benefit reimbursement	Must use Kaiser providers, except in emergency	Must use Providence Health Plan participating providers, except in emergency and urgent care situations
How the plan pays benefits	Plan pays covered charges at 80% of UCR* after you meet the annual deductible; you pay 20% plus any charges above UCR*	Most covered services paid in full after applicable copayment	Office visits are covered 100% after you pay a \$10 copayment; most other covered services are paid at 90%
Annual† deductible	\$200/individual, \$600/family	None	None
Annual† out-of-pocket maximum	Generally \$1,000 per person, per calendar year, after the annual deductible. Additional covered expenses paid at 100% for the remainder of the year	\$600/individual, \$1,200/family	\$1,200/individual, \$2,400/family
Covered Services	What the plan pays	What the plan pays	What the plan pays
Physician services			
Office visits (including mental health and chemical dependency)	80% of UCR* after deductible	100% after you pay a \$5 copayment per visit	100% after you pay a \$10 copayment per visit
Hospital visits (including mental health and chemical dependency)	80% of UCR* after deductible	100%	90%
Preventive care services			
Periodic health exams and well-baby care	100%, according to frequency schedule***	100%, according to frequency schedule***	100%, according to frequency schedule***
Routine immunizations	100%, according to frequency schedule***	100%, according to frequency schedule***	100%, according to frequency schedule***
Lab and x-ray	80% of UCR* after deductible	100%	90%
Emergency care	80% of UCR* after deductible; deductible waived if accident treated within 90 days	Kaiser or non-Kaiser facility: 100% after you pay a \$25 copayment, in or outside the service area; waived if admitted	Providence or non-Providence facility: 100% after you pay a \$100 copayment; waived if admitted within 24 hours
Urgent care	80% of UCR* after deductible; deductible waived if accident treated within 90 days	Kaiser facility: 100% after you pay a \$5 office visit copayment, in service area or any facility outside service area	Providence or non-Providence facility: 100% after you pay a \$10 copayment
Hospital facility services			
Acute hospital care (including mental health and chemical dependency)	80% of UCR* after deductible	100%	90%

* Usual, customary and reasonable charges *** Contact your medical plan for schedule details † Based on Calendar year

Effective February 1, 2011

Medical & Prescription Drug Benefits (continued)

	Trust Indemnity Plan	Kaiser Permanente HMO	Providence Personal Option EPO
Covered services	What the plan pays	What the plan pays	What the plan pays
Maternity services			
Pre- and post-natal care	80% of UCR* after deductible; covered for members and spouse/domestic partner only	100%	100% after you pay a \$10 copayment per visit
Delivery and hospital services	80% of UCR* after deductible; covered for members and spouse/domestic partner only	100%	90%
Alternative care			
	80% of UCR* after Deductible	Chiropractic only: 100% after you pay a \$10 copayment per visit; up to 20 visits per calendar year	Chiropractic only: 100% after you pay a \$10 copayment per visit; up to 20 visits per calendar year
Prescription drugs			
Outpatient Retail	Participating CAREMARK® pharmacies (per 34-day supply): 100% after you pay a \$5 copayment for generic, \$10 for brand name‡ (can purchase up to 3 monthly supplies) Non-participating pharmacies: 80% after you pay an annual \$50 per person deductible	Kaiser pharmacies (up to 30-day supply): 100% after you pay a \$5 copayment for generic, \$10 for brand name	Participating CAREMARK® pharmacies (per 34-day supply): 100% after you pay a \$5 copayment for generic, \$10 for brand name‡ (can purchase up to 3 monthly supplies) Non-participating pharmacies: 80% after you pay an annual \$50 per person deductible
Outpatient Mail order (per 90-day supply)	CAREMARK® mail order service: 100% after you pay a \$5 copayment for generic, \$10 for brand name‡	Kaiser mail order service: 100% after you pay a \$5 copayment for generic, \$10 for brand name	CAREMARK® mail order service: 100% after you pay a \$5 copayment for generic, \$10 for brand name‡

*Usual, customary and reasonable charges

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

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 www.sdtrust.com or from the Trust Office. Providence and Kaiser plan booklets are only available from Customer Service:

Providence **503-574-7500** (Portland) or **1-800-878-4445**

Kaiser **503-813-2000** (Portland) or **1-800-813-2000**



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