



THE TRUST

School District No. 1
Health and Welfare Trust

Trust Health Benefits for PAT Early Retirees

Effective February 1, 2011

Medical & Prescription Drug Benefits				
	Trust Indemnity Early Retiree Plan 1	Trust Early Retiree PPO Plan 2	Kaiser Permanente HMO	Providence Personal Option (EPO) Plan
Provider choice	May use any provider; may save on out-of-pocket costs if you use Providence Preferred or Beech Street network providers	May use any provider; may save on out-of-pocket costs if you use Providence Preferred or Beech Street network providers	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 two types of benefits: Basic Benefit: Plan pays up to certain benefit amount whether or not you have met the annual deductible and before Major Medical benefits apply Major Medical Benefit: Plan pays 80% of UCR* after you meet the annual deductible and after any Basic Benefits are paid. You pay 20% plus any charges above UCR*	After you meet the annual deductible, plan pays at percentage of covered charges PPO: 90% Non-PPO: 70% of UCR*	Most covered services paid in full after applicable copayment	Most covered services paid in full after applicable copayment
Annual† deductible	\$200/individual, \$400/family	\$200/individual, \$400/family	None	None
Annual† out-of-pocket maximum	Generally \$1,000 per person per calendar year after the annual deductible	PPO: \$1,000 per person after the annual deductible Non-PPO: \$3,000 per person after the annual deductible	\$600/individual, \$1,200/family	\$700/individual, \$2,000/family
Covered services	What the plan pays	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	PPO: 90% after deductible Non-PPO: 70% after deductible	100% after you pay a \$5 copayment per visit	100% after you pay a \$5 copayment per visit
Hospital visits (including mental health and chemical dependency)	\$10 per visit, then 80% of UCR* after deductible	PPO: 90% after deductible Non-PPO: 70% after deductible	100%	100%
Inpatient surgery and anesthesiology	Basic Benefit, then 80% of UCR* after deductible	PPO: 90% after deductible Non-PPO: 70% after deductible	100%	100%
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***	100% according to frequency schedule***
Routine immunizations	100% according to frequency schedule***	100% according to frequency schedule***	100% according to frequency schedule***	100% according to frequency schedule***

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	Trust Indemnity Early Retiree Plan 1	Trust Early Retiree PPO Plan 2	Kaiser Permanente HMO	Providence Personal Option (EPO) Plan
Outpatient services				
Lab and x-ray	80% of UCR* after deductible	PPO: 90% after deductible Non-PPO: 70% after deductible	100%	100%
Emergency services Emergency or afterhours care from participating providers	First \$500, then 80% of UCR* after deductible; additional accident benefit for treatment within 90 days. Hospital emergency room outpatient accident treatment within 7 days paid at 100%	PPO: 90% after deductible Non-PPO: 90% after deductible	Emergency room: Kaiser or non-Kaiser facility: 100% after you pay a \$25 copayment in or outside the service area; waived if admitted Urgent care: Kaiser facility: Plan pays 100% after you pay a \$5 copayment, in service area or any facility outside service area	Emergency room: Providence or non-Providence facility: 100% after you pay a \$50 copayment; waived if admitted Urgent care: Providence or non-Providence facility: 100% after you pay a \$5 copayment; waived if admitted
Alternative care	80% of UCR* after deductible, for chiropractic, naturopathy, acupuncture	Not covered	Not covered	Not covered; discounts available through Providence Health Plan's "Choose Healthy" program
Hospital facility service				
Acute hospital care (including mental health and chemical dependency)	\$70 per day, then 80% of UCR* after deductible	PPO: 90% after deductible Non-PPO: 70% after deductible	100%	100%
Skilled nursing facility	\$70 per day, then 80% of UCR* after deductible	80% of UCR* after deductible; up to 100 days when authorized	100% up to 100 days per year in an approved facility when authorized	100% up to 60 days per spell of illness
Durable medical equipment	80% of UCR* after deductible	80% of UCR* after deductible	80%	80%
Vision	Not covered. You may be eligible to enroll in Trust Vision Plan on a self-pay basis	Not covered. You may be eligible to enroll in Trust Vision Plan on a self-pay basis	100% after a \$5 copayment for exam; 100% up to \$100 credit for lenses and frames once every two years	Not covered. You may be eligible to enroll in Trust Vision Plan on a self-pay basis
Prescription drugs				
Outpatient Retail	You pay in full, then submit claim to Trust for 80% reimbursement after deductible; discount at participating CAREMARK® pharmacies	You pay in full, then submit claim to Trust for 80% reimbursement after deductible; discount at participating CAREMARK® pharmacies	Kaiser pharmacies (up to 30-day supply): You pay 50% of cost of drug, up to \$50 maximum copayment	Participating CAREMARK® pharmacies (per 30-day supply): pay 50% of cost of drug, up to \$50 for generic†
Outpatient mail order (90 day supply)			Kaiser mail order service: You pay 50% of cost of drug, up to \$100 maximum copayment	CAREMARK® mail order service: You pay 50% of cost of drug, up to \$150 for generic†

*Usual, customary and reasonable charges *** 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

Note: These charts show only major plan features. For details, refer to the plan booklets, available on www.sdtrust.com or from the Trust Office. Providence and Kaiser

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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

Trust Dental/Vision Options on a Self-Pay Basis

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You pay the full cost of the Early Retiree Trust Dental/Vision coverage. For details on your benefit costs, refer to PAT Early Retiree rate sheet.

Basic Dental/Vision		Buy-Up Dental/Vision		
Dental				
Provider choice	Any licensed dentist		Any licensed dentist	
Annual individual deductible	\$50		None	
Covered services	What the plan pays	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*	
Prosthetic 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	
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	
Vision	VSP Network Provider	Non-VSP Provider	VSP Network Provider	Non-VSP Provider
Routine Eye Exam	Covered in full after \$25 copayment	Covered up to \$45 after \$25 copayment	Covered in full	Covered up to \$70
Lenses				
Single vision	Standard lenses paid in full after \$25 copayment	Covered up to \$45 after \$25 copayment	Standard lenses paid in full	Covered up to \$50
Lined Bifocal	Standard lenses paid in full after \$25 copayment	Covered up to \$65 after \$25 copayment	Standard lenses paid in full	Covered up to \$75
Lined Trifocal	Standard lenses paid in full after \$25 copayment	Covered up to \$85 after \$25 copayment	Standard lenses paid in full	Covered up to \$100
Progressive	15-20% discount off usual and customary charges for progressive lens option	Covered up to \$85 after \$25 copayment	15-20% discount off usual and customary charges for progressive lens option	Covered up to \$100
Frames	Covered up to \$120, 20% discount off any remaining balance	Covered up to \$47	Covered up to \$100, 20% discount off any remaining balance	Covered up to \$75
Contact lenses in lieu of lenses and frames	Covered up to \$105	Covered up to \$105	Covered up to \$137	Covered up to \$137
Benefit Frequency				
Exam	Every 24 months for children and adults		Every 12 months for children up to age 17, every 24 months for adults	
Lenses	Every 24 months for children and adults		Every 12 months for children up to age 17, every 24 months for adults	
Frames	Every 24 months for children and adults		Every 24 months for children and adults	

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Additional discounts through VSP providers

Lasik eye surgery	Discounts are available from participating Lasik surgery providers; contact VSP for further information	Discounts are available from participating Lasik Surgery providers; contact VSP for further information
Additional vision hardware or services over plan allowance	20% discount off additional pairs of complete glasses; discounts available for cosmetic options. 15% discount on professional services for contact lenses.	20% discount off additional pairs of complete glasses; discounts available for cosmetic options. 15% discount on professional services for contact lenses.

*Usual, customary and reasonable charges

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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