



Trust Health Benefits for PFTCE, DCU and ATU Early Retirees

Effective February 1, 2011

| Medical & Prescription Drug Benefits | | | |
|---|--|--|--|
| | Providence Open Option Plan | Kaiser Permanente HMO | Providence Personal Option (EPO) Plan |
| Provider choice | May use covered providers; may save on out-of-pocket costs if you use Providence Health Plan participating 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 | After you meet the annual deductible, plan pays at percentage of covered charges In-network: 80% Out-of-network: 60% of UCR* | Most covered services paid in full after applicable copayment | Office visits covered at 100% after a \$10 copayment per visit; most other services covered at 90%. |
| Annual [†] deductible | \$250/individual, \$750/family | None | None |
| Annual [†] out-of-pocket maximum | \$1,700/individual, \$5,100/family; maximum does not include deductible or prescription drugs | \$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) | In-network: 100% after you pay a \$10 copayment per visit** Out-of-network: 60%** of UCR* | 100% after you pay a \$20 copayment per visit | 100% after you pay a \$10 copayment per visit |
| Hospital visits (including mental health and chemical dependency) | In-network: 80% after deductible Out-of-network: 60% of UCR* after deductible | 100% | 90% |
| Preventive care services | | | |
| Periodic health exams & well-baby care | In-network: 100%, according to frequency schedule*** Out-of-network: 60%** of UCR* | 100%, according to frequency schedule*** | 100%, according to frequency schedule*** |
| Routine immunizations | In-network: 100%, according to frequency schedule*** Out-of-network: 60%** of UCR* | 100%, according to frequency schedule*** | 100%, according to frequency schedule*** |
| Outpatient services | | | |
| Lab and x-ray | In-network: 80%** Out-of-network: 60% of UCR* after deductible | 100% | 90% |
| Emergency services | | | |
| Emergency or urgent care from participating providers | Emergency room: In-network or Out-of-network: 100% after you pay a \$100 copayment**; waived if admitted within 24 hours Urgent care: In-network or Out-of-network: 100% after you pay a \$10 copayment**; waived if admitted within 24 hours | 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 \$20 copayment, in service area or any facility outside service area | Emergency room: Providence or non-Providence facility: 100% after you pay a \$100 copayment; waived if admitted within 24 hours Urgent care: Providence or non-Providence facility: 100% after you pay a \$10 copayment; waived if admitted |

*Usual, customary and reasonable charges

*** Contact your medical plan for schedule details †Based on calendar year

Continued on the next page

** Deductible does not apply

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

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| | Providence Open Option Plan | Kaiser Permanente HMO | Providence Personal Option (EPO) Plan |
|---|---|---|---|
| Covered services | What the plan pays | What the plan pays | What the plan pays |
| Hospital facility service | | | |
| Acute hospital care (including mental health and chemical dependency) | In-network: 80% after deductible Out-of-network: 60% of UCR* after deductible | 100% | 90% |
| Skilled nursing facility | In-network: 80% after deductible Out-of-network: 60% of UCR* after deductible; up to 60 days per calendar year | 100% up to 100 days per year in an approved facility when authorized | 90% up to 60 days per spell of illness |
| Durable medical equipment | In-network: 80% after deductible Out-of-network: 60% of UCR* after deductible | 80% | 80% |
| Alternative care | Not covered under medical plan; discounts available through Providence Health Plan's "Choose Healthy" program | Not covered | Not covered under medical plan; discounts available through Providence Health Plan's "Choose Healthy" program |
| Vision | Not covered; you may be eligible to enroll in Trust Vision Plan on a self-pay basis | 100% after a \$20 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 | | | |
| Retail | Participating and preferred retail pharmacies for up to 30-day supply: You pay a \$15 or 50% copayment, whichever is greater for generic and brand name‡ | 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): You pay 50% of cost of drug, up to \$50 for generic or brand‡ |
| Mail Order (per 90 day supply) | Mail order and preferred retail pharmacies for up to a 90-day supply: You pay a \$45 or 50% copayment, whichever is greater for generic and brand name‡ Mail order pharmacies: Postal Prescription Services, Walgreens Mail Service and Wellpartner Preferred retail pharmacies: Costco, Fred Meyer, Safeway, Walgreens and QFC | Kaiser mail order service (per 90-day supply): You pay 50% of cost of drug, up to \$100 maximum copayment | CAREMARK® mail order service (per 90-day supply): You pay 50% of cost of drug, up to \$150 for generic or brand‡ |

*Usual, customary and reasonable charges

**Deductible does not apply

†Based on calendar year

‡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, from the Trust office. Providence and Kaiser plan booklets are only available from Customer Service:

Providence 503-454-3842 (Portland) or 1-800-878-4445

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

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Trust Dental/Vision Options on a Self-Pay Basis

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

*Usual, customary and reasonable charges

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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 |

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 |



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School District No. 1
Health and Welfare Trust