

**WESTERN STATES HEALTH AND WELFARE TRUST FUND OF THE OPEIU**  
2010 PLAN YEAR

**Active Employees Benefit Options**

	LIFEWISE		KAISER PERMANENTE
	PPO		HMO
	PPO Network Provider	Non-Network Provider	
<b>Providers / Hospitals</b>	LifeWise of Oregon providers and facilities	Any licensed provider or facility	Kaiser Permanente providers and facilities
<b>Lifetime Maximum</b>	\$2,000,000		Unlimited
<b>Calendar Year Deductible</b>	\$300 / Individual - \$600 / Family		N/A
<b>Medical Calendar Year Out-of-Pocket Maximum</b>	\$2,000 + Deductible / Individual \$4,000 + Deductible / Family	\$6,000 + Deductible / Individual \$12,000 + Deductible / Family	\$1,250 / Individual \$2,500 / Family
<b>Physician Services</b>	<b>INSURED PAYS:</b>		<b>INSURED PAYS:</b>
<ul style="list-style-type: none"> <li>▪ Office Visits</li> <li>▪ Routine Physical Exams</li> <li>▪ Well Baby/Child Care</li> <li>▪ Maternity</li> </ul>	<ul style="list-style-type: none"> <li>▪ \$20 office visit copay*<sup>1</sup></li> <li>▪ \$20 office visit copay*<sup>2</sup></li> <li>▪ \$20 office visit copay*<sup>2</sup></li> <li>▪ \$250 copay per pregnancy*<sup>3</sup></li> </ul>	<ul style="list-style-type: none"> <li>▪ 40% after deductible<sup>1</sup></li> <li>▪ 40% after deductible<sup>2</sup></li> <li>▪ 40% after deductible<sup>2</sup></li> <li>▪ 40% after deductible</li> </ul>	<ul style="list-style-type: none"> <li>▪ \$15 office visit copay</li> <li>▪ \$15 office visit copay</li> <li>▪ \$15 office visit copay<sup>4</sup></li> <li>▪ Covered in Full</li> </ul>
<b>Other Professional Services</b>	<b>INSURED PAYS:</b>		<b>INSURED PAYS:</b>
<ul style="list-style-type: none"> <li>▪ Routine Lab and X-Ray</li> <li>▪ CT SCANS, MRI, PET Scans</li> <li>▪ DME/Supplies</li> <li>▪ Alternative Care</li> </ul>	<ul style="list-style-type: none"> <li>▪ 20%, deductible waived</li> <li>▪ 20%, deductible waived</li> <li>▪ 20% after deductible</li> <li>▪ \$20 office visit copay*<sup>5</sup></li> </ul>	<ul style="list-style-type: none"> <li>▪ 40% after deductible</li> <li>▪ 40% after deductible</li> <li>▪ 40% after deductible</li> <li>▪ 40% after deductible</li> </ul>	<ul style="list-style-type: none"> <li>▪ \$20 copay per visit</li> <li>▪ \$20 copay per visit</li> <li>▪ 20%</li> <li>▪ Not Covered</li> </ul>
<b>Hospital Services</b>	<b>INSURED PAYS:</b>		<b>INSURED PAYS:</b>
<ul style="list-style-type: none"> <li>▪ Inpatient Services</li> <li>▪ Surgeon/Anesthesiologist Services</li> <li>▪ Inpatient Rehab Care</li> </ul>	<ul style="list-style-type: none"> <li>▪ 20% after deductible</li> <li>▪ 20% after deductible</li> <li>▪ 20% after deductible<sup>6</sup></li> </ul>	<ul style="list-style-type: none"> <li>▪ 40% after deductible</li> <li>▪ 40% after deductible</li> <li>▪ 40% after deductible<sup>6</sup></li> </ul>	<ul style="list-style-type: none"> <li>▪ \$100 copay/day (\$500 Maximum Per Calendar Year)</li> <li>▪ Covered in Full</li> <li>▪ Covered in Full</li> </ul>
<b>Outpatient Surgery Facility Fee and Procedure</b>	<ul style="list-style-type: none"> <li>▪ 20% after deductible</li> </ul>	<ul style="list-style-type: none"> <li>▪ 40% after deductible</li> </ul>	<ul style="list-style-type: none"> <li>▪ \$15 copay per procedure</li> </ul>
<b>Emergency Room Services</b>	<ul style="list-style-type: none"> <li>▪ \$75 copay, then 20% after deductible – waived if admitted</li> </ul>		<ul style="list-style-type: none"> <li>▪ \$75 copay plus any supplemental charges</li> </ul>
<b>Mental Health / Chemical Depend.</b>	As required by Oregon State Mandates		
<b>Prescription Drugs</b>	<i>Benefit through Express Scripts</i>		
<ul style="list-style-type: none"> <li>▪ Pharmacy – Retail (30 days)</li> <li>▪ Mail Order (90 days)</li> </ul>	<ul style="list-style-type: none"> <li>▪ \$10/20% Generic / \$20/20% Preferred Brand / 50% non-Preferred Brand</li> <li>▪ \$20/20% Generic / \$40/20% Preferred Brand / 50% non-Preferred Brand</li> </ul>	<ul style="list-style-type: none"> <li>▪ \$15 Generic / \$30 Brand</li> <li>▪ \$30 Generic / \$60 Brand</li> </ul>	
<b>Prescription Drug Calendar Year Out-of-Pocket Maximum</b>	<ul style="list-style-type: none"> <li>▪ \$10,000 per Individual</li> </ul>		<ul style="list-style-type: none"> <li>▪ None</li> </ul>

\* Deductible waived.

**DISCLAIMER: This is a summary of benefits only. Any errors or omissions are purely unintentional.**

<sup>1</sup> Allergy Shots & Therapeutic injections (serum not included) and other office procedures are covered at 20% after the deductible for In-Network providers and at 40% after the deductible for Non-Network providers.

<sup>2</sup> \$500 per calendar year (PCY) maximum for preventive service. Routine Immunizations/Vaccinations are covered in full and not included in PCY limit for In-Network providers and 40% for Non-Network providers.

<sup>3</sup> Maternity In-Network copay covers Prenatal, Delivery & Postnatal Physician Services. Mother and newborn are subject to separate deductible and coinsurance for hospital services.

<sup>4</sup> \$0 copay for prenatal care; \$15 copay for children over age 2.

<sup>5</sup> Alternative Care includes: Chiropractic, Naturopathic, and Acupuncture. Providers are the LifeWise network and limited to \$1,500 PCY.

<sup>6</sup> Inpatient Rehab Care: 60 day maximum PCY.

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<b>VISION COVERAGE</b>			
	Vision Service Plan (VSP) for <b>LIFEWISE</b> members		Kaiser Permanente members
	VSP Providers	Non-VSP Providers <sup>7</sup>	Kaiser Permanente providers only
	<b>INSURED PAYS:</b>	<b>INSURED REIMBURSEMENT:</b>	<b>INSURED PAYS:</b>
<b>Exams</b>	\$15 Copay	\$15 Copay then up to \$45	\$15 copay
<b>Lenses</b> ▪ <b>Single</b> ▪ <b>Bifocal - Lined</b> ▪ <b>Trifocal - Lined</b>	\$25 Copay	\$25 Copay then: ▪ Up to \$45 ▪ Up to \$65 ▪ Up to \$85	▪ Allowance of \$150 for lenses, frames or contacts <sup>8</sup> If full balance is not used in the initial visit, the balance is forfeited.
<b>Frames</b>	Allowance of \$130	Up to \$47	
<b>Contact Lenses</b> (in lieu of Frames/Lenses)	Allowance of \$130	Up to \$105	Professional fitting and follow-up for contact lenses is required in order for contacts to be dispensed. You will pay an additional fee. You may not use the optical allowance for those additional fees.
<b>Frequency</b> (based on last date of service) ▪ <b>Exam</b> ▪ <b>Lenses</b> ▪ <b>Frames</b>	▪ 12 Months ▪ 12 Months ▪ 24 Months	▪ 12 Months ▪ 12 Months ▪ 24 Months	▪ 12 Months ▪ 24 Months ▪ 24 Months
<b>DENTAL COVERAGE</b>			
Services	Trust Indemnity Plan	Willamette Dental Group <sup>9</sup>	Kaiser Permanente <sup>10</sup>
	<b>INSURED PAYS:</b>	<b>INSURED PAYS:</b>	<b>INSURED PAYS:</b>
<b>Calendar Year <u>Individual</u> Deductible</b>	▪ \$10	▪ No Deductible; \$10 visit charge	▪ No Deductible; \$5 visit charge
<b>Calendar Year Dental Maximum</b>	▪ \$1,500 – <b>PLAN PAYS</b>	▪ None	▪ None
<b>Orthodontia Lifetime Maximum</b>	▪ \$1,000 – <b>PLAN PAYS</b>	▪ N/A	▪ 50% up to \$1,000 – <b>PLAN PAYS</b>
<b>Services</b> ♦ <b>Preventive Care</b> (exams, cleanings) ♦ <b>Basic</b> (fillings, simple extractions) ♦ <b>Prosthetic</b> (crowns, bridges, dentures) ♦ <b>Orthodontia</b>	▪ 20% ▪ 20% ▪ 20% <sup>11</sup> ▪ 50%	▪ 20% of UCR <sup>12</sup> ▪ 20% of UCR <sup>12</sup> ▪ 20% of UCR <sup>12</sup> ▪ 50% of UCR <sup>12</sup>	▪ \$10 visit charge ▪ \$10 visit charge ▪ \$10 visit charge + applicable copay's <sup>13</sup> ▪ \$2,400 plus \$10 visit copay, each visit
			▪ \$5 visit charge ▪ \$5 visit charge + 20% ▪ \$5 visit charge + 50% ▪ \$5 visit charge + 50%

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<sup>7</sup> Services and eyewear obtained through out-of-network providers are subject to the same copayment and limitations as services obtained through VSP doctors.

<sup>8</sup> The benefit will cover replacement eyeglasses or contact lenses if your prescription changes .50 diopter or more within 12 months of your initial exam. Replacement lenses are for the original product type and covered up to: \$60 for single-vision or contact lenses; \$90 for multifocal lenses.

<sup>9</sup> Willamette Dental is available to Oregon and Vancouver, WA residents only.

<sup>10</sup> Kaiser dental is available to all members – one does not need to be enrolled on Kaiser medical.

<sup>11</sup> Actual benefit varies, refer to your labor contract

<sup>12</sup> UCR – Usual, customary and reasonable

<sup>13</sup> Copay's vary \$75-\$225 based on services received.