2015 SAIF Corporation Providence Health Plan

Premium rates	SAIF pays			Employee pays		
Level of plan coverage	**Low**	**Medium**	**High**	**Low**	**Medium**	**High**
Employee only	$604.46	$560.07	$488.95	$0	$30	$60
Employee + spouse or domestic partner	$1,198.65	$1,110.89	$968.65	$0	$60	$120
Employee + child(ren)	$1,107.16	$1,026.46	$895.38	$0	$55	$110
Employee + family (includes spouse or domestic partner	$1,818.53	$1,686.38	$1,472.00	$0	$90	$180

Spouse or domestic partner premium share	Spouse or domestic partner premium rates
Spouse or domestic partner with no other group coverage	$0
Spouse or domestic partner with other group coverage or premium	$297
Spouse or domestic partner opts out of other group coverage	$594

Deductible & out-of-pocket expenses	In network			Out of network		
Level of plan coverage	**Low**	**Medium**	**High**	**Low**	**Medium**	**High**
Annual deductible per plan member	$250	$750	$1,250	$750	$2,250	$3,750
Annual family deductible (3 or more)	$750	$2,250	$3,750	$2,250	$4,500	$7,500
Annual maximum per person (out-of-pocket)	$2,250	$2,750	$3,250	$15,750	$17,250	$18,750
Annual family maximum (out-of-pocket—3 or more)	$6,750	$8,250	$9,750	$47,250	$49,500	$52,500
Lifetime benefit maximum	None	None	None	None	None	None

Preventive care services		
Annual (calendar year) gynecological exams, pap tests	Covered in full ✓	30% ✓
Follow-up visit (1) after annual gynecological exam	Covered in full ✓	30% ✓
Periodic health exams (age based schedule; from a personal physician/provider only)	Covered in full ✓	30% ✓
Well-baby care (PHP age based schedule; from a personal physician/provider only)	Covered in full ✓	30% ✓
Annual mammography screening	Covered in full ✓	30% ✓
Prostrate screening exam (calendar year)	Covered in full ✓	30% ✓
Lab services (tests received with your health maintenance exam: CBC, urinalysis, chemical profile, glucose, cholesterol, fecal blood)	Covered in full ✓	30% ✓
Diabetes (following services HbA1c, retinal exam, urine test for kidney function, diabetic exams of mouth, teeth and feet)	Covered in full ✓	30% ✓
Nutritional counseling (limit 2 visits per calendar year when medically necessary)	Covered in full ✓	30%
Routine immunizations/shots (adults & children); pneumococcal vaccine; flu vaccine	Covered in full ✓	30% ✓
Colorectal exam, colorectal cancer screening; sigmoidoscopy (every 5 years); or, colonoscopy, once every 10 years; all after age 50 (provider and facility);	Covered in full ✓	30%
Hearing screenings (see hearing aid benefit summary)	Covered in full ✓	30% ✓
Tobacco use cessation; counseling/classes, and deterrent medications, including prescription and OTC. Medications must be purchased at a participating pharmacy	Covered in full ✓	Not Covered

Physician/provider services		
Office visits	$25 ✓	30% ✓
Office visits to naturopaths, chiropractors and acupuncturists	$25 ✓	30% ✓
Spinal manipulation and acupuncture	See spinal manipulation & acupuncture benefit summary	
Inpatient hospital visits	$25	30%
Allergy shots and serums, injectable medications	$25	30%
Surgery and anesthesia at a provider's office	$25/provider	30%
Surgery and anesthesia at a facility	$100/provider/day	30%

Hospital services		
Inpatient care	10%	30%
Observation care	10%	30%
Rehabilitative care (30 days per calendar year)	10%	30%
Skilled Nursing facility (60 days per calendar year)	10%	30%

Maternity		
Maternity services prenatal	Covered in full ✓	30%
Maternity services delivery and postnatal	$250/delivery ✓	30%
Maternity inpatient hospital/facility services	10%	30%
Routine newborn nursery care	10% ✓	30%

Medical and diabetes supplies, durable medical equipment, appliances, prosthetic devices	10%	30%
Medical equipment, appliances and supplies	10%	30%
Removable custom shoe orthotics are limited to $200 per calendar year	10%	30%
Diabetic supplies including lancets, test strips, selected glucometers	Covered in full✓	30%

Emergency/urgent care/ambulance services (copay waived if admitted to hospital within 24 hours)		
Emergency services (for emergency medical conditions only)	$125	$125 in plan deductible applies
Urgent care services (for non-life threatening illness/minor injury)	$25/visit ✓	$25/visit ✓
Ambulance and emergency medical transportation services	$125	$125, in plan deductible applies

Diagnostic services		
Lab services	10%	30%
X-ray services	10%/provider/day	30%
High tech Imaging procedures (MRI, CAT, PET, SPECT) diagnostic (pre-authorization required)	10%/provider/day	30%
Sleep studies	10%	30%
Self-administered chemo therapy (Up to a 30-day supply from a designated participating pharmacy) Generic drugs; -Formulary brand-name drugs; -Non-formulary brand-name drugs	Covered in full ✓	Not Covered

Other covered services		
Outpatient surgery (facility)	10%	30%
Outpatient dialysis, chemotherapy & radiation therapy	Covered in full ✓	30%
Outpatient rehabilitative services (30 visits/calendar year)	10%	30%
Bariatric surgery for morbid obesity*	10%	30%
Tempomandibular joint (TMJ) services (limited to $1,000/calendar year; $5,000/lifetime max.)	50%	Not Covered
Home health care	Covered in full ✓	30%
Hospice care	Covered in full ✓	Covered in full ✓
Self-administered chemo therapy (Up to a 30-day supply from a designated participating pharmacy) -Generic drugs; -Formulary brand-name drugs; -Non-formulary brand-name drugs	Covered in full ✓	Not Covered

Mental health/chemical dependency		
(To initiate services, you must call 1.800.711.4577. All inpatient, residential and day or partial hospitalization treatment services must be prior authorized.)		
Inpatient and residential services	10%	30%
Day treatment, intensive outpatient, and partial hospitalizations services	10%	30%
Applied behavior analysis	10%	30%
Outpatient provider visits	$25/visit ✓	30% ✓

Prescription Drugs	
Annual Rx max per person (out-of pocket)	**Copayments and coinsurance apply to medical plan out-of-pocket maximums**
At pharmacy—30-day supply	**Total 30-day cost**
Value Tier (Tier 1)	$0
Tier 2—Generic	$10
Tier 3—Brand	$30
Tier 4—Non-formulary and compounded	50%
Mail order (90 day supply x 3 co-pays)	**Total 90-day mail order cost or participating retail pharmacy cost:**
Value Tier (Tier 1) ($0)	$0
Tier 2—Generic ($10)	$30
Tier 3—Brand ($30)	$90
Tier 4—Non-formulary (50%)	50%

✓ No deductible needs to be met prior to receiving this benefit

Employees can call Providence Health Plan with questions from Portland at 503.574.7500, or all other areas 1.800.878.4445

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*Requires prior approval by Providence based on certain criteria being met. See Providence summary plan description for specific requirements related to this benefit.

2015 SAIF Corporation Kaiser Permanente Medical Plan

Premium rates	SAIF pays			Employee pays		
Level of plan coverage	**Low**	**Medium**	**High**	**Low**	**Medium**	**High**
Employee only	$591.95	$551.26	$483.16	$0	$30	$60
Employee + spouse or domestic partner	$1,183.91	$1,102.52	$966.31	$0	$60	$120
Employee + child(ren)	$1,065.52	$991.27	$867.68	$0	$55	$110
Employee + family (includes spouse or domestic partner	$1,775.86	$1,653.78	1,449.47	$0	$90	$180

Spouse or Domestic Partner Premium Share	Spouse or domestic partner premium rates
Spouse or domestic partner with no other group coverage	$0
Spouse or domestic partner with other group coverage or premium	$296
Spouse or domestic partner opts out of other group coverage	$592

Deductible & out-of-pocket expenses	Kaiser network		
Level of plan coverage	**Low***	**Medium**	**High**
Annual deductible per plan member	None	$500	$1,000
Annual family deductible (3 or more)	None	$1,500	$3,000
Annual maximum per person (out-of-pocket)	$2,000	$2,500	$3,000
Annual family maximum (out-of-pocket—3 or more)	$4,000	$5,000	$6,000
Lifetime benefit maximum	None	None	None

Preventive care services	Low	Medium	High
Preventive care exams (adult, children, well-baby)	$0	$0 ✓	$0 ✓
Prenatal care and first post-partum visit	$0	$0 ✓	$0 ✓
Immunizations (all ages)	$0	$0 ✓	$0 ✓
Annual gynecological exams, pap tests exam	$0	$0 ✓	$0 ✓
X-ray and lab for preventive care	$0	$0 ✓	$0 ✓
Flex sigmoidoscopy and colonoscopy	$0	$0 ✓	$0 ✓
Annual mammography screening	$0	$0 ✓	$0 ✓
Screening prostate-specific antigen (PSA) test (not including monitoring or ultrasensitive tests)	$0	$0 ✓	$0 ✓
Diabetes (following services HbA1c, retinal exam, urine test for kidney function, diabetic exams of mouth, teeth and feet)	$0	$0 ✓	$0 ✓
Tobacco use cessation (8-12 weeks of treatment per attempt at quitting tobacco use. Only if in conjunction with a Kaiser tobacco cessation program approved by Kaiser that uses nicotine replacement therapy. Covered drugs include prescribed nicotine gum and patches. Medications must be purchased at a Kaiser pharmacy)	$0	$0 ✓	$0 ✓

Professional and outpatient services			
Primary care	$15	$15 ✓	$15 ✓
Specialty care office visit	$15	$15 ✓	$15 ✓
Allergy shots at nurse treatment room	$10	$10 ✓	$10 ✓
Outpatient rehabilitation (20 visits per year per therapy)	$15	$15	$15
X-ray, imaging, and lab for diagnostic procedures	10%	10%	10%
Imaging (i.e. PET, CAT, MRI)	10%	10%	10%
Outpatient surgery visit	10%	10%	10%
Outpatient administered medications (all outpatient settings)	20%	10%	10%
Hearing aids for children (limited to one hearing aid per ear every four years per member age 18 years and younger, or enrollees age 19 to 25 and enrolled in an accredited educational institution)	20%	10%	10%
Hearing aids (ages 19 years and older)	Balance after $500 allowance is applied for each hearing aid per ear every three years.		
Alternative care (physician-referred) limited to 12 visits per calendar year	$15	$15	$15
Alternative care services (self-referred) limited to 12 visits per calendar year	$15 naturopath, chiropractic, acupuncture; $25 massage therapy; $1,500 maximum benefit per member per year		

Maternity care			
Scheduled prenatal care & first postpartum visit	$0	$0	$0
Laboratory, X-ray, imaging, and special diagnostic procedures	10%	10% ✓	10% ✓
Inpatient hospital services	$100/day up to $500/calendar year	10%	10%

Medical and diabetes supplies, durable medical equipment, appliances, prosthetic devices			
Selected glucometers (test strips and lancets under Rx benefit)	$0	$0	$0
Diabetic supplies and insulin	$0	$0	$0
Durable medical equipment other than diabetic supplies	20%/$0 for diabetic supplies	10%/$0 for diabetic supplies	10%/$0 for diabetic supplies

Hospital services			
Inpatient care (includes room, board, surgery, anesthesia, x-ray, imaging, laboratory, and prescription drugs)			
Inpatient care and surgery	$100 per day, up to $500 per calendar year	10%	10%
Outpatient facility	10%	10%	10%
Bariatric inpatient hospital services**	$100 per day, up to $500 per calendar year	10%	10%

Emergency/urgent care/ambulance services			
(Your emergency/urgent co-pay is waived if admitted to hospital within 24 hours)			
Emergency services (for emergency medical conditions only)	$125	10%	10%
Urgent care services (for non-life threatening illness or minor injury)	$15	$15 ✓	$15 ✓
Ambulance services (for emergency transportation only per transport)	$100	10%	10%

Home health/skilled nursing facility			
Home health (up to 130 visits per calendar year)	$0	10%	10%
Inpatient skilled nursing services (up to 100 days per calendar year)	$0	10%	10%

Mental health/chemical dependency			
Inpatient hospital and residential services	$100 per day, up to $500 per calendar year	10%	10%
Outpatient provider visits	$15	$15 ✓	$15 ✓

Prescription drugs			
Annual Rx max per person (out-of pocket)	None	None	None
At pharmacy—30-day supply			
Generic	$10	$10	$10
Brand	$25	$25	$25
Mail order (90 day supply x 2 co-pays for maintenance medications)			
Generic	$20	$20	$20
Brand	$50	$50	$50

*The low-cost plan has no deductible; therefore, all care will be received without a deductible requirement.

**Bariatric surgery services are covered for clinically severe obesity only when certain medical criteria have been met.

✓ No deductible needs to be met prior to receiving this benefit.

This is not an all-inclusive summary of SAIF's policies with this health care provider. This is a summary only; it does not fully describe your benefits coverage. For detailed information on your benefits, refer to the online Kaiser Group Agreement and Evidence of Coverage.

SAIF 2015 Dental Plan Summaries

	Kaiser DHMO Plan		Kaiser dental choice PPO		Moda dental		Willamette Dental Group	
Premium Rates	**SAIF Pays**	**Employee Pays**	**SAIF Pays**	**Employee Pays**	**SAIF Pays**	**Employee Pays**	**SAIF Pays**	**Employee Pays**
Employee	$49.33	$26.73	$52.39	$0	$49.33	$0	$44.05	$0
Employee + spouse/DP	$97.66	$52.94	$104.78	$0	$97.66	$0	$87.20	$0
Employee + child	$101.61	$55.08	$94.30	$0	$101.61	$0	$90.70	$0
Employee + family	$154.88	$83.94	$157.17	$0	$154.88	$0	$138.25	$0
Annual Deductible	None		$25 per individual, $75 per family/calendar year		$25 per individual, $75 per family/calendar year		None	
Annual Benefit Maximum	None		$2,000 per individual/calendar year		$2,000 per individual/calendar year		None	
	Services Diagnostic & Preventive		**Services Diagnostic & Preventive**		**Services Diagnostic & Preventive**		**Services Diagnostic & Preventive**	
Examinations	100% after $10 copay		100%	If you use a non-participating provider, the co-insurance you pay will be at the same level as if you were using a participating provider. However, non-participating providers will be paid by Kaiser according to the fee schedule allowed for participating providers. As a member of this plan, you may be billed by the provider for the difference between the scheduled fee and the actual charge billed by the provider.	100% (once every 6 months)		Paid at 100%, after $10 copay	
Cleanings	100% after $10 copay		100%		100% (once every 6 months)		Paid at 100%, after $10 copay	
X-rays	100% after $10 copay		100%		100% (bitewing once every 6 months and full mouth x-rays once every 3 years)		Paid at 100%, after $10 copay	
Fluoride Treatment	100% after $10 copay		100%		100% (once every 6 months)		Paid at 100%, after $10 copay	
RESTORATIVE								
Routine Fillings	100% after $10 copay		80%		80%		Paid at 100%, after $10 copay	
Extractions	100% after $10 copay		80%		80%		Paid at 100%, after $10 copay	
Root Canals	100% after $10 copay		80%		80%		Paid at 100%, after $10 copay	
Periodontal Surgery	100% after $10 copay		80%		80%		Paid at 100%, after $10 copay	
Oral Surgery	100% after $10 copay		50%		80%		Paid at 100%, after $10 copay	
MAJOR								
Crowns (gold or porcelain)	$10 plus $45/crown		50%*		50%		Paid at 100%, after $10 copay	
Bridges	$10 plus $45/bridge		50%		50%		Paid at 100%, after $10 copay	
Dentures	$10 plus $95/partial denture; $65/full denture; $25/reline		50%		50% (once every 5 years)		Paid at 100%, after $10 copay	
ORTHODONTIA								
Orthodontia	50% of charges with no dollar maximum (children to age 18, no adult ortho)		50% of charges with no dollar maximum (children to age 18, no adult ortho)		50% Benefit amount of $500 lifetime maximum per adult or child member		Pre-orthodontia Treatment you pay $150 copay (this is credited toward comprehensive ortho service) Comprehensive orthodontia treatment you pay $1,800 copay per adult or child member	
DENTAL IMPLANTS								
	50% up to $2,000 annual maximum implant benefit		50% up to $2,000 annual maximum implant benefit		50%, included in the $2,000 annual maximum benefit		20% discount on implant services. Service must be approved and performed by a Willamette Dental Group provider. Contact WDG for information.	
	When medically necessary due to tooth damage or loss		*When medically necessary due to tooth damage or loss*		*When medically necessary due to tooth damage or loss*			

* Kaiser Dental Choice Plan: Plastic and stainless steel crowns covered at 80%

This is not an all-inclusive summary of SAIF's policies with these dental care providers.This is a benefit summary only and does not fully describe your benefits coverage. Employees should call the dental care plan they are enrolled in for questions regarding personal dental needs. For provider numbers refer to the benefit carriers phone directory on Life@SAIF.

SAIF 2015 VSP Vision Benefit Summary

Premium rates	SAIF pays	Employee pays	
Level of plan coverage	**VSP base and buy-up plan**	**VSP base plan**	**VSP buy-up plan**
Employee only	$6.48	$0	$4.94
Employee + spouse or domestic partner	$12.04	$0	$9.94
Employee + child(ren)	$12.80	$0	$10.66
Employee + family (includes spouse or domestic partner)	$19.92	$0	$17.04

Plan services	VSP base plan coverage (with VSP doctors and affiliate providers*)	VSP buy-up plan coverage (with VSP doctors and affiliate providers*)
Eye exam (adults) every 12 months/enrolled member and prescription glasses	$25 copay	$25 copay
Eye exam (children up to 19) Two exams, every 12 months/enrolled member and prescription glasses	$25 copay	$25 copay
Lenses	Every 24 months	Every 12 months
Single vision lenses, lined bifocal, lined trifocal lenses	Yes	Yes
Progressive lenses	No	$30 copay
Anti-reflective coating	No	$30 copay
Avg. 35%-40% savings on other lens enhancements	Yes	Yes
Frames	Every 24 months	Every 12 months
Frame allowance	$120	$160
Fame allowance at Costco Optical	$60	$90
Frame cost savings over allowance	20%	20%
Contact lenses (instead of glasses)	Every 24 months	Every 12 months
Contact lens exam (fitting and evaluation)	$60 copay	$60 copay
Contact lens allowance	$120	$160
Children glasses		
Lens allowance	2 per service year**	2 per service year**
Polycarbonate lenses for dependent children	Yes	Yes
Frame allowance	Every 12 months	Every 12 months
Frame allowance cost	$120	$160
Frame cost savings over allowance	20%	20%
Computer glasses (separate specialty plan)	Every 24 months	Every 12 months
Copay	$25 in addition to annual copay	$25 in addition to annual copay
Frame allowance	$90	$90
Lenses	$0	$0

Out-of-network provider benefits	Every 24 months	Every 12 months
Exam allowance	$50	$50
Single vision lenses allowance	$50	$50
Lined bifocal lenses allowance	$75	$75
Lined trifocal lenses allowance	$100	$100
Frame allowance	$70	$70
Contacts allowance	$105	$145

*Coverage with a retail chain VSP affiliate may be different. KidsCare plan is only available at VSP doctors. This benefit is not available at a retail chain VSP affiliate. Check vsp.com for VSP providers and SAIF vision benefits.

**Service year is the benefit year from the last date of your eye visit/exam or eligibility for glasses.

This is not an all-inclusive summary of SAIF's policies with Vision Service Plan. This is a benefit summary only and does not fully describe your benefits coverage. For more detailed information about your benefits, please refer to the online member information at vsp.com or call Member Services at 800.877.7195.