

Rate Information Chart – 2008

Monthly Rate Information

Medical Coverage	Employee Only	Employee and Spouse/ Domestic Partner	Employee and Children	Employee and Family
OHSU PPO Plan	\$528.96	\$795.38	\$628.24	\$836.20
250 PPO Plan	\$577.36	\$868.12	\$685.50	\$946.26
60/50 PPO Plan	\$516.40	\$776.52	\$613.32	\$816.48
Kaiser Permanente	\$571.76	\$851.92	\$668.96	\$891.96

Dental Coverage	Employee Only	Employee and Spouse/ Domestic Partner	Employee and Children	Employee and Family
ODS Dental Plan	\$40.52	\$88.20	\$98.50	\$142.78
Kaiser Permanente	\$66.98	\$133.96	\$120.56	\$200.94
Willamette Dental Insurance Inc.	\$34.08	\$66.40	\$60.20	\$103.10

Short-Term Disability	Pay Date Options		
	8th Day	30th Day	90th Day
	0.0108 of your biweekly earnings	0.0026 of your biweekly earnings	0.0007 of your biweekly earnings

Long -Term Disability	Pay Date Options
	180th Day
	0.0046 of your biweekly earnings

Plan Feature	OHSU Preferred Provider Plan (PPO)	
BASICS	OHSU Provider	Non-OHSU Provider
How the plan works	Pays benefits for covered services from any qualified provider or hospital. To receive the highest level of benefits, you must use an OHSU preferred provider, hospital or clinic.	
What the plan pays for most covered services	80%, after the deductible	60% of allowable charges, after the deductible
Annual deductible — <i>applies to all services unless otherwise noted</i>	\$200/person \$600/family	
Annual out-of-pocket maximum — <i>includes deductible</i>	\$1,200/person \$2,600/family	\$2,200/person \$4,600/family
Lifetime maximum benefit	\$2,000,000	
IN THE DOCTOR'S OFFICE		
Home and office visits	\$25 copayment	60% of allowable charges
Routine physicals (limited to the plan schedule) — includes well child care \$400 maximum benefit per year	100%, no deductible subject to frequency limitations	60% of allowable charges subject to frequency limitations
OB/GYN annual exams	100%, no deductible subject to frequency limitations	60% of allowable charges subject to frequency limitations
Well baby care	100%, no deductible subject to frequency limitations	60% of allowable charges subject to frequency limitations
IN THE HOSPITAL		
Inpatient physician services	80%	60% of allowable charges
Hospital/facility charges	80%	60% of allowable charges
Emergency care	\$30 copayment, then 80%, copayment waived if admitted	\$30 copayment, then 80% of allowable charges; copayment waived if admitted
OTHER COVERED SERVICES		
Maternity	80% of allowable charges	60% of allowable charges
Chemical dependency		
Outpatient	80% of allowable charges	60% of allowable charges
Inpatient	80% of allowable charges	60% of allowable charges
Mental Health		
Outpatient	80% of allowable charges	60% of allowable charges
Inpatient	80% of allowable charges	60% of allowable charges
SERVICES PROVIDED BY OTHER PLANS		
Prescription Drug Benefits PharmaCare Preferred Drug Plan (PDP)	Participating pharmacy Plan pays: Generic: 70% Preferred brand: 70% Non-preferred brand: 50% No deductible \$1,000 out-of-pocket maximum per family \$10 minimum copayment per prescription	Non-participating pharmacy Plan pays amount equivalent to PDP costs minus the applicable coinsurance amount No deductible \$1,000 annual out-of-pocket maximum per family \$10 minimum copayment per prescription
Vision Benefits Vision Service Plan (VSP) Exam allowed every 12 months, lenses and frames every 24 months	VSP providers: Exam paid in full; standard allowance for lenses and frames after \$25 copayment; up to \$140 allowance for elective contacts and exam No deductible	Non-VSP providers: Exam reimbursed up to \$42; lenses and frames partially reimbursed after \$25 copayment; up to \$140 allowance for elective contacts and exam No deductible

Plan Feature		250 PPO Plan	
BASICS		Preferred Provider	Non-preferred Provider
How the plan works	Pays benefits for covered services you receive from any qualified provider or hospital. To receive the highest level of benefits, you must use an Aetna Preferred Provider.		
What the plan pays for most covered services	80%, after the deductible	60% of allowable charges, after the deductible	
Annual deductible — <i>applies to all services unless otherwise noted</i>	\$250/person \$750/family		
Annual out-of-pocket maximum — <i>includes deductible</i>	\$2,250/person \$4,750/family	\$4,250/person \$8,750/family	
Lifetime maximum benefit	\$2,000,000		
IN THE DOCTOR'S OFFICE			
Home and office visits	\$25 copayment	60% of allowable charges	
Routine physicals (limited to the plan schedule) — includes well child care \$400 maximum benefit per year	100%, no deductible subject to frequency limitations	60% of allowable charges	
OB/GYN annual exams	100%, no deductible subject to frequency limitations	60% of allowable charges, subject to frequency limitations	
Well baby care	100%, no deductible; subject to frequency limitations	60% of allowable charges, subject to frequency limitations	
IN THE HOSPITAL			
Inpatient physician services	80%	60% of allowable charges	
Hospital/facility charges	80%	60% of allowable charges	
Emergency care	\$30 copayment, then 80%, copayment waived if admitted	\$30 copayment, then 80% of allowable charges, copayment waived if admitted	
OTHER COVERED SERVICES			
Maternity	80% of allowable charges	60% of allowable charges	
Chemical dependency			
Outpatient	80% of allowable charges	60% of allowable charges	
Inpatient	80% of allowable charges	60% of allowable charges	
Mental Health			
Outpatient	80% of allowable charges	60% of allowable charges	
Inpatient	80% of allowable charges	60% of allowable charges	
SERVICES PROVIDED BY OTHER PLANS			
Prescription Drug Benefits PharmaCare Preferred Drug Plan (PDP)	Participating pharmacy Plan pays: Generic: 70% Preferred brand: 70% Non-preferred brand: 50% No deductible \$1,000 out-of-pocket maximum per family \$10 minimum copayment per prescription	Non-participating pharmacy Plan pays amount equivalent to PDP costs minus the applicable coinsurance amount No deductible \$1,000 annual out-of-pocket maximum per family \$10 minimum copayment per prescription	
Vision Benefits Vision Service Plan (VSP) <i>Exam allowed every 12 months, lenses and frames every 24 months</i>	VSP providers: Exam paid in full; standard allowance for lenses and frames after \$25 copayment; up to \$140 allowance for elective contacts and exam No deductible	Non-VSP providers: Exam reimbursed up to \$42; lenses and frames partially reimbursed after \$25 copayment; up to \$140 allowance for elective contacts and exam No deductible	

Plan Feature	60/50 PPO Plan	
BASICS	Preferred Provider	Non-preferred Provider
How the plan works	Pays benefits for covered services you receive from any qualified provider or hospital. To receive the highest level of benefits, you must use an Aetna Preferred Provider.	
What the plan pays for most covered services	60%	50% of allowable charges, after the deductible
Annual deductible — <i>applies to all services unless otherwise noted</i>	None	None
Annual out-of-pocket maximum — <i>includes deductible</i>	\$8,000/person \$16,000/family	\$10,000/person \$20,000/family
Lifetime maximum benefit	\$2,000,000	
IN THE DOCTOR'S OFFICE		
Home and office visits	60%	50% of allowable charges
Routine physicals (limited to the plan schedule) — includes well child care \$400 maximum benefit per year	100%	50% of allowable charges
OB/GYN annual exams	100% subject to frequency limitations	50% of allowable charges subject to frequency limitations
Well baby care	100%; subject to frequency limitations	50% of allowable charges; subject to frequency limitations
IN THE HOSPITAL		
Inpatient physician services	60%	50% of allowable charges
Hospital/facility charges	60%	50% of allowable charges
Emergency care	\$100 copayment (waived if admitted), then 100%	\$100 copayment (waived if admitted), then 100%
OTHER COVERED SERVICES		
Maternity	60% of allowable charges	50% of allowable charges
Chemical dependency		
Outpatient	60% of allowable charges	50% of allowable charges
Inpatient	60% of allowable charges	50% of allowable charges
Mental Health		
Outpatient	60% of allowable charges	50% of allowable charges
Inpatient	60% of allowable charges	50% of allowable charges
SERVICES PROVIDED BY OTHER PLANS		
Prescription Drug Benefits PharmaCare Preferred Drug Plan (PDP)	Participating pharmacy Plan pays: Generic: 70% Preferred brand: 70% Non-preferred brand: 50% No deductible \$1,000 out-of-pocket maximum per family \$10 minimum copayment per prescription	Non-participating pharmacy Plan pays amount equivalent to PDP costs minus the applicable coinsurance amount No deductible \$1,000 annual out-of-pocket maximum per family \$10 minimum copayment per prescription
Vision Benefits Vision Service Plan (VSP) <i>Exam allowed every 12 months, lenses and frames every 24 months</i>	VSP providers: Exam paid in full; standard allowance for lenses and frames after \$25 copayment; up to \$140 allowance for elective contacts and exam	Non-VSP providers: Exam reimbursed up to \$42; lenses and frames partially reimbursed after \$25 copayment; up to \$140 allowance for elective contacts and exam

Plan Feature	Kaiser Permanente
BASICS	
How the plan works	Except for emergencies, all care must be provided by Kaiser Permanente's participating providers at Kaiser Permanente facilities.
What the plan pays for most covered services	100% after any applicable copayments
Annual deductible — <i>applies to all services unless otherwise noted</i>	None
Annual out-of-pocket maximum — <i>includes deductible</i>	\$1,000/person \$2,000/family
Lifetime maximum benefit	None
IN THE DOCTOR'S OFFICE	
Home and office visits	\$15 copayment
Routine physicals (limited to the plan schedule) — includes well child care	\$15 copayment
OB/GYN annual exams	\$15 copayment
Well baby care	\$15 copayment, covered as necessary
IN THE HOSPITAL	
Inpatient physician services	Paid in full
Hospital/facility charges	\$200 copayment per admission
Emergency care	\$75 copayment at Kaiser and non-Kaiser facilities (waived if admitted)
OTHER COVERED SERVICES	
Maternity	Covered the same as any other condition
Chemical dependency — Limits are per 24-month benefit period	
Outpatient	\$15 copayment, up to 40 visits
Inpatient	80% up to \$5,000 for children and \$5,625 for adults
Mental Health — Limits are per 24-month benefit period	
Outpatient	\$15 copayment, up to 40 visits
Inpatient	\$100 copayment per day up to \$500 per stay, covered up to 16 days for children and adults
SERVICES PROVIDED BY OTHER PLANS	
Prescription Drug Benefits	Benefit through Kaiser Permanente: \$15 copayment per formulary prescription at Kaiser pharmacies
Vision Benefits <i>Exam allowed every 12 months, lenses and frames every 24 months</i>	Benefit through Kaiser Permanente: \$15 copayment for exams (not limited). Lenses, frames and/or contacts covered up to \$150 every 24 months.