Dental Plan Options

	MetLife *(1-800-942-0854 • www.metlife.com/mybenefits)*	
	Option 1	**Option 2**
Annual Deductible	**$50** for each covered person	**$50** for each covered person
Annual Benefit Maximum *(excluding orthodontics)*	**$2,000** per person	**$1,000** per person
Diagnostic and Preventive Benefits	**100%**[1] *(deductible does not apply)*	**100%**[1] *(deductible does not apply)*
Therapeutic and Restorative Services and Supplies *(fillings, extractions, root canals)*	**80%**[1] after deductible	**80%**[1] after deductible
Major and Prosthodontic Services and Supplies *(crowns, inlays, onlays, dentures)*	**50%**[1] after deductible	**50%**[1] after deductible
Oral Surgery	**80%**[1] after deductible	**80%**[1] after deductible
Temporomandibular Joint *(TMJ)* **Treatment**	Not covered	Not covered
Orthodontics	**100%**[1] after deductible *$2,000 per-person lifetime benefit maximum; up to age 19*	Not covered

[1] Services performed by out-of-network providers are subject to reasonable and customary (R&C) charges.

Vision Plan

	VSP *(1-800-877-7195 • www.vsp.com)*			
	VSP Preferred Providers	**Non-VSP Preferred Providers**	**VSP Buy Up Preferred Providers**	**Non-VSP Buy Up Preferred Providers**
Routine Eye Exam *(once per calendar year)*	**100%** after $10 copay	Plan pays up to **$45** after $10 copay	**100%** after $10 copay	**100%** after $10 copay
Diabetic Eyecare Plus Program *(medical eyecare related to type 1 and type 2 diabetes)*	**100%** after $20 copay	None	**100%** after $20 copay	None
Prescription Glasses *(frame and lenses)*	**After $25 copay:** Lenses once per calendar year Frames every other calendar year • Up to **$150** allowance for a wide selection of frames; **$170** frame allowance for featured brands, plus **20%** off any out-of-pocket costs • Up to **$80** for frames purchased at Costco • Single vision, lined bifocal, and lined trifocal lenses, as well as polycarbonate lenses for dependent children, are covered in full	**After $25 copay:** • Frame: **$70** • Single vision: **$45** • Lined bifocal: **$65** • Lined trifocal: **$85** • Progressive: **$50**	**After $10 copay:** Lenses once per calendar year **Frames every calendar year** • Up to **$250** allowance for a wide selection of frames; **$270** allowance for featured brands, plus **20%** off any out-of-pocket costs • Up to **$135** for frames purchased at Costco • Single vision, lined bifocal, and lined trifocal lenses, as well as polycarbonate lenses for dependent children, are covered in full; anti-reflective coating covered at $25	**After $25 copay:** • Frames: **$70** • Single vision: **$45** • Lined bifocal: **$65** • Lined trifocal: **$85** • Progressive: **$50**
Contacts, Elective *(once per calendar year in lieu of frame and lenses)*	**Copay up to $60** Plan pays up to **$155** no copay; contact lens exam fitting and evaluation	Plan pays up to **$105**[2]	**Copay up to $60** Plan pays up to a **$200** allowance; standard and premium contact lens fitting and evaluation exam covered after copay	**Copay up to $60** Plan pays up to **$105** no copay; contact lens exam fitting and evaluation

[2] Copays may apply when contacts are medically necessary. Learn more from your provider or visit **www.vsp.com**.

Extra Discounts and Savings

When visiting a VSP preferred provider, you'll receive:

- An average of 20%–25% savings on all non-covered lens options, such as progressives and scratch-resistant and anti-reflective coatings. You pay only the added cost of these optional enhancements. The plan covers the cost for basic lenses (as described above).
- 20% off additional glasses and sunglasses, including lens options, purchased from the same VSP provider who provided your eye exam, if ordered on the same day as your eye exam. Or get 20% off prescription glasses and sunglasses from any VSP provider, if ordered within 12 months of your last eye exam.
- Up to $39 copay for routine retinal screening as an enhancement to your WellVision exam.
- Laser vision correction discounts. At discounted facilities, get an average of 15% off the regular price or 5% off the promotional price.

The information in this table is a summary of your benefits coverage. Nothing contained in this table is intended to create or imply a contract, and the company has the right to amend or terminate these plans at any time. See the Summary Plan Description for a complete description of your benefits. You may request a written copy at PacifiCorp Employee Benefits, 825 NE Multnomah Street, Suite 1800, Portland, OR 97232-2135.

10/2018

2019 — Comparing Your Medical Plan Options

All plans (except Kaiser) are administered by Wellmark: **1-800-287-4511** • **www.mywellmark.com** • Mobile app: **www.wellmark.com/gomobile**
Kaiser: **1-503-813-2000** (in Portland) • **1-800-813-2000** (outside Portland) • **www.kp.org**

	Definity CDHP with HSA *(Consumer-Driven Health Plan)* Benefits indicated are after deductible, except as noted.				**Deductible Plan** *(With PPO option)* Benefits indicated are after deductible, except as noted.						**Kaiser Permanente HMO Plan[1]** *(Oregon and southwest Washington only)*
	Local 127 and BCC Represented		**Local 659**		**Local 127**		**Local 659**		**BCC Represented** *(hired before 3/25/2011)*		
	Discounted Providers	**Non-Discounted Providers**	**Discounted Providers**	**Non-Discounted Providers**	**PPO Providers**	**Non-PPO Providers**	**PPO Providers**	**Non-PPO Providers**	**PPO Providers**	**Non-PPO Providers**	
Health Savings Account *(HSA)*	**$500** *(employee-only coverage)*; **$1,000**/family		**$450** *(employee-only coverage)*; **$900**/family		Not applicable						Not applicable
Annual Deductible	In-network: **$1,500**/person; **$3,000**/family Out-of-network: **$3,000**/person; **$6,000**/family		**$1,500**/person; **$3,000**/family		**$400**/person; **$800**/family		**$600**/person; **$1,200**/family		**$300**/person; **$600**/family		**$500**/person; **$1,500**/family
Annual Out-of-Pocket Maximum	In-network: **$3,500**/person; **$6,850**/family *(includes deductible)* Out-of-network: **$6,000**/person; **$12,000**/family		**$3,000**/person; **$6,000**/family *(includes deductible)*		**$2,000**/person; **$4,000**/family		**$2,500**/person; **$5,000**/family		**$1,500**/person; **$3,000**/family		**$3,000**/person; **$9,000**/family *(basic health services only)*
Outpatient Services *Physician and Specialist Office Visits*	**80%**[2]	**60%**[2]	**85%**[2]	**65%**[2]	Physician: **100%** after $20 copay per visit Specialist: **100%** after $30 copay per visit	**80%**[3]	Physician: **$25** copay per visit Specialist: **$35** copay per visit	**80%**[3]	Physician: **100%** after $25 copay per visit Specialist: **100%** after $35 copay per visit	**80%**[3]	Primary Care Physician: **100%** after $20 copay per visit Specialist: **100%** after $30 copay per visit Allergy shots and immunizations *(other than preventive care)*: **100%** after $10 copay
Preventive/Well-Adult Care (routine physical exams, OB/GYN exams, immunizations, and inoculations)	**100%** *(no deductible)*	**60%**[2] *(no deductible)*	**100%** *(no deductible)*		In-network: **100%** (no deductible) Out-of-network: **80%**[3] (no deductible)		In-network: **100%** (no deductible) Out-of-network: **60%**[3] (no deductible)		In-network: **100%** (no deductible) Out-of-network: **80%**[3] (no deductible)		**100%**
Well-Child Care (up to age six, including immunizations and inoculations)	**100%** *(no deductible)*	**60%**[2] *(no deductible)*	**100%** *(no deductible)*		In-network: **100%** *(no deductible)* Out-of-network: **80%**[3] *(no deductible)*		In-network: **100%** *(no deductible)* Out-of-network: **60%**[3] *(no deductible)*				**100%**
Maternity Care	**80%**[2]	**60%**[2]	**85%**[2]	**65%**[2]	**$20** copay, then 100% for first prenatal visit Subsequent visits: **80%** Delivery charges and postnatal visit: **80%**	**80%**[3]	**$25** copay, then 100% for first prenatal visit Subsequent visits: **80%** Delivery charges and postnatal visit: **80%**	**80%**[3]	**$25** copay, then 100% for first prenatal visit Subsequent visits: **80%** Delivery charges and postnatal visit: **80%**	**80%**[3]	**100%** prenatal care Delivery charges: **90%** after deductible per admission at Kaiser facilities
Physical Therapy	**80%**[2]	**60%**[2]	**85%**[2]	**65%**[2]	**80%** *Periodic medical review required*	**80%**[3]	**80%** *Periodic medical review required*	**80%**[3]	**80%** *Periodic medical review required*	**80%**[3]	**100%** after $30 copay per visit *Limited to 20 visits per therapy per calendar year*
Prosthetic Devices/Durable Medical Equipment (DME)	**80%**[2]	**60%**[2]	**85%**[2]	**65%**[2]	**80%**[3]						**90%** after deductible
Hospital Inpatient Services *(room and board and ancillary charges)*	**80%**[2] *All inpatient care requires prenotification*	**60%**[2] *All inpatient care requires prenotification*	**85%**[2] *All inpatient care requires prenotification*	**65%**[2] *All inpatient care requires prenotification*	**80%** *Benefit reduced $250 if not preapproved*	**80%**[3]	**80%** *Benefit reduced $250 if not preapproved*	**80%**[3]	**80%** *Benefit reduced $250 if not preapproved*	**80%**[3]	**90%** after deductible
Surgery Physician Services *(inpatient and outpatient)*	**80%**[2]	**60%**[2]	**85%**[2]	**65%**[2]	**80%**	**80%**[3]	**80%**	**80%**[3]	**80%**	**80%**[3]	**90%** after deductible
Outpatient Surgical Facilities	**80%**[2]	**60%**[2]	**85%**[2]	**65%**[2]	**80%** after $50 copay	**80%**[3]	**80%** after $50 copay	**80%**[3]	**80%** after $50 copay	**80%**[3]	**90%** after $100 copay
Emergency Room Care	**80%**[2]	**60%**[2]	**85%**[2]	**65%**[2]	**100%** after $50 copay *(waived if admitted)*	**100%** after $50 copay[3,4]	**100%** after $50 copay *(waived if admitted)*	**100%** after $50 copay[3,4]	**100%** after $50 copay *(waived if admitted)*	**100%** after $50 copay[3,4]	**90%** after deductible
Urgent Care Center	**80%**[2]	**60%**[2]	**85%**[2]	**65%**[2]	**100%** after $35 copay	**80%**[3]	**100%** after $35 copay	**80%**[3]	**100%** after $35 copay	**80%**[3]	**100%** after $40 copay at Kaiser facilities
Ambulance Services	**80%**[2]	**60%**[2]	**85%**[2]	**65%**[2]	**80%**[3]						**90%** after deductible
X-ray/Lab	**80%**[2] *Inpatient X-ray and lab are part of facility claim*	**60%**[2] *Inpatient X-ray and lab are part of facility claim*	**85%**[2] *Inpatient X-ray and lab are part of facility claim*	**65%**[2] *Inpatient X-ray and lab are part of facility claim*	**80%**	**80%**[3]	**80%**	**80%**[3]	**80%**	**80%**[3]	**100%** after $40 copay at Kaiser facilities; **$100** copay for CAT, PET, and MRI exams
Hospice Care	**80%**[2]	**60%**[2]	**85%**[2]	**65%**[2]	**100%**[3] *(no deductible)*		**80%**[3]		**80%**[3]		**100%** for patients diagnosed with life expectancy of six months or less
Employee Assistance Program *(EAP)*	First eight visits are free; preauthorization required. *Provided by Health Advocate*				First eight visits are free; preauthorization required. *Provided by Health Advocate*						First eight visits are free; preauthorization required. *Provided by Health Advocate*
Mental Health Care/Chemical Dependency *(inpatient and outpatient)*	Covered same as "Outpatient Services" and "Hospital Inpatient Services" above, precertification required. *Provided by Health Advocate*				Covered same as "Outpatient Services" and "Hospital Inpatient Services" above, precertification required. *Provided by Health Advocate*						Covered same as "Outpatient Services" and "Hospital Inpatient Services" above. *Provided by Kaiser*
Chiropractic Care, Christian Science Practitioners[5], Acupuncture, and Naturopathic Care	**80%**[2] *Maximum 25 visits annually per benefit*	**60%**[2] *Maximum 25 visits annually per benefit*	**85%**[2] *Maximum 25 visits annually per benefit*	**65%**[2] *Maximum 25 visits annually per benefit*	**80%**[3] *Maximum 25 visits annually per benefit*						**100%** after $25 copay per visit *$1,000 annual maximum benefit* *No acupuncture benefit*
Hearing Care	**80%**[2] Hearing devices: Up to **$400** allowed *(per ear device over a three-plan-year period)*		**85%**[2] Hearing devices: Up to **$400** allowed *(per ear device over a three-plan-year period)*	**65%**[2] Hearing devices: Up to **$400** allowed *(per ear device over a three-plan-year period)*	**60%** *(no deductible)* Hearing devices: Up to **$400** allowed *(per ear device over a three-plan-year period)*						Not covered
Prescription Drugs[6]	**Retail pharmacy and mail-order** *(Express Scripts)*: 80% for generic, 70% for formulary brand, and 60% for nonformulary brand.				Annual Rx Out-of-Pocket Maximum: **$4,600**/person; **$9,200**/family **Retail 30-day supply** *(at an Express Scripts network pharmacy)*: You pay the greater of a $10 copay or 20% coinsurance for generic; you pay the greater of a $25 copay or 30% coinsurance for formulary brand; you pay the greater of a $40 copay or 40% coinsurance for nonformulary brand. **Retail 90-day supply** *(at an Express Scripts network pharmacy)*: You pay the greater of a $30 copay or 20% coinsurance for generic; you pay the greater of a $75 copay or 30% coinsurance for formulary brand; you pay the greater of a $120 copay or 40% coinsurance for nonformulary brand. **Mail-order 90-day supply** *(Express Scripts)*: You pay a $20 copay for generic; $50 copay for formulary brand; $100 copay for nonformulary brand.		Annual Rx Out-of-Pocket Maximum: **$4,100**/person; **$8,200**/family **Retail 30-day supply** *(at an Express Scripts network pharmacy)*: You pay the greater of a $10 copay or 20% coinsurance for generic; you pay the greater of a $30 copay or 30% coinsurance for formulary brand; you pay the greater of a $50 copay or 40% coinsurance for nonformulary brand. **Retail 90-day supply** *(at an Express Scripts network pharmacy)*: You pay the greater of a $30 copay or 20% coinsurance for generic; you pay the greater of a $90 copay or 30% coinsurance for formulary brand; you pay the greater of a $150 copay or 40% coinsurance for nonformulary brand. **Mail-order 90-day supply** *(Express Scripts)*: You pay a $20 copay for generic; $60 copay for formulary brand; $120 copay for nonformulary brand.		Annual Rx Out-of-Pocket Maximum: **$5,100**/person; **$10,200**/family **Retail 30-day supply** *(at an Express Scripts network pharmacy)*: You pay the greater of a $10 copay or 20% coinsurance for generic; you pay the greater of a $30 copay or 30% coinsurance for formulary brand; you pay the greater of a $50 copay or 40% coinsurance for nonformulary brand. **Retail 90-day supply** *(at an Express Scripts network pharmacy)*: You pay the greater of a $30 copay or 20% coinsurance for generic; you pay the greater of a $90 copay or 30% coinsurance for formulary brand; you pay the greater of a $150 copay or 40% coinsurance for nonformulary brand. **Mail-order 90-day supply** *(Express Scripts)*: You pay a $20 copay for generic; $60 copay for formulary brand; $120 copay for nonformulary brand.		**Retail 30-day supply:** You pay a $20 copay for generic; $40 copay for formulary brand; $60 copay for nonformulary brand. **Retail 90-day supply:** You pay a $40 copay for generic; $60 copay for formulary brand. **Mail-order 90-day supply:** You pay a $40 copay for generic; $80 copay for formulary brand; $120 copay for nonformulary brand. *Nonformulary drugs covered with physician consult and Kaiser approval.*

1 Coverage for dependents living outside the service area is for emergencies only. Contact Kaiser for more information.

2 If you live outside the Wellmark network area, you will receive the higher coinsurance level. Benefits for services received from non-discounted providers are subject to reasonable and customary (R&C) charges.

3 Provider charges are subject to reasonable and customary (R&C) charges. Facility charges may also be subject to R&C. Check with plan.

4 If the admission is not for an emergency but is for a covered service, you will receive lower benefits.

5 Available only for Local 659 Definity CDHP with HSA Plan and Local 127 $400 Deductible Plan.

6 Brand name drugs will automatically be filled with generic equivalent. If you choose brand name, you will pay generic drug copay plus the cost difference between generic and brand name.