RATES

ATU TYPE 10 DRIVERS—APRIL 1–SEPTEMBER 30, 2021

ATU

HEALTH & WELFARE TRUST
SCHOOL DISTRICT NO.1

12205 SW Tualatin Rd., Suite 200
Tualatin, OR 97062
833-255-4123 (toll-free) or 503-486-2107
sdtrust.com

Medical, Prescription, Dental Plans

ATU Type 10 Driver coverage includes:
Medical, Prescription, Dental, and Vision

MEDICAL/Rx/VISION	Choose One of These Plans*		
Plan Name	**Kaiser Permanente Plan**	**Providence Personal Option Plan**	**Providence Option Advantage Plan**
Medical			
How the Plan Pays Benefits Copays and deductible waived for commonly used in-network services	The Plan pays 100% of most covered services after you pay the copay No out-of-network coverage except emergency care and urgent care when traveling.	The Plan pays 100% for most covered services after you pay copays and deductible No out-of-network coverage except emergency care.	The Plan pays 100% for most in-network covered charges after you pay copays and deductible, and 60% of UCR for out-of-network covered charges
Provider Choices	Choose a Provider in these networks: • Kaiser Permanente: **kp.org** • The Portland Clinic: **theportlandclinic.com**	Choose a Provider in the Providence Network: **ProvidenceHealthPlan.com/members**	You may choose any Provider, but your out-of-pocket costs will be lower when you choose a Provider in the Providence Network: **ProvidenceHealthPlan.com/members**
Prescription	**Kaiser Permanente**	**Trust Prescription Drug Plan**	
Retail and Mail Order Available	Use Kaiser Permanente pharmacies and mail order	Use Express-Scripts	
Vision	**Kaiser Vision Plan**	**Trust Vision Plan (Administered by VSP)**	
Provider Choice	Use Kaiser Permanente Providers	Use VSP Providers	
Your Out-of-Pocket Costs			
Annual Medical Deductible	$100/individual $300/family	$100/individual $200/family	$100/individual $200/family
Annual Medical Out-of-Pocket Maximum	$600/individual $1,200/family	$1,200/individual $2,400/family	$1,200/individual $2,400/family
Annual Prescription Out-of-Pocket Maximum	Prescription expenses apply to the medical out-of-pocket maximum	$2,200/individual $4,400/family	$2,200/individual $4,400/family

*You must enroll in a Dental Plan if you enroll in a Medical/Prescription Plan.

This is an overview of commonly used services. For additional Plan comparisons, go to **sdtrust.com**. Rates are evaluated annually and are subject to change. If there is a conflict between these charts and the official Plan documents, provisions of the official Plan documents will govern how the Plans work and how the Plans pay benefits.

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DENTAL	Choose One of These Dental Plans*	
Plan Name	**Kaiser Permanente Dental**	**Trust Dental Plan/Delta Dental of Oregon**
Provider Choice	Use Kaiser Permanente providers	Use any provider; save money with an in-network provider
Dependent Dental Coverage	Yes	Yes
Your Costs		
Annual Dental Plan Deductible	None	None
Maximum Annual Dental Benefit	$2,500	$2,500

* You must be enrolled in a Medical/Prescription Plan to enroll in a Dental Plan.

MONTHLY CONTRIBUTION RATES			
Plan Name	**Kaiser Permanente Plan**	**Providence Personal Option Plan**	**Providence Option Advantage Plan**
Includes Kaiser Dental Plan			
Full-Time Member Only	$73.46	$173.22	$194.78
Full-Time Member + one dependent	$749.54	$953.64	$996.78
Full-Time Member + Family	$1,267.56	$1,741.20	$1,805.86
Includes Trust Dental Plan (Delta Dental of Oregon)			
Full-Time Member Only	$65.38	$165.14	$186.70
Full-Time Member + one dependent	$734.38	$938.48	$981.62
Full-Time Member + Family	$1,241.36	$1,715.00	$1,779.66