BENEFITS OVERVIEW

ATU TYPE 10 DRIVERS—APRIL 1–SEPTEMBER 30, 2023

ATU

HEALTH & WELFARE TRUST
SCHOOL DISTRICT NO.1

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	Kaiser Permanente*	Providence In-Network Only Plan**	Providence PPO Plan
Office Visits for primary, naturopathy or specialty care	You pay $10 copay; then Plan pays 100% **Naturopathy:** $10 per visit **Pediatric**: no copay	You pay $10 copay; then Plan pays 100% **Naturopathy:** $10 per visit	**In-Network:** You pay $10 copay, then Plan pays 100% (Naturopathy: $10 per visit) **Out-of-Network:** You pay 40%, Plan pays 60%
Preventive Health Exams and Well-Baby Care (Frequency schedule applies)	You pay $0; Plan pays 100%	You pay $0; Plan pays 100%	**In-Network:** You pay $0, Plan pays 100% **Out-of-Network:** You pay 40%, Plan pays 60%
Labs and X-rays	You pay $0; Plan pays 100%	You pay $0; Plan pays 100%	**In-Network:** You pay $0, Plan pays 100% **Out-of-Network:** You pay 40%, Plan pays 60%
Maternity Care	**Pre- and post-natal:** You pay $0; Plan pays 100% **Delivery and hospital services:** The Plan pays 100%	**Pre- and post-natal:** You pay $0; Plan pays 100% **Delivery and hospital services:** You pay $100; then Plan pays 100%	**Pre- and post-natal—In-Network:** You pay $0, Plan pays 100% **Out-of-Network:** You pay 40%, Plan pays 60% **Delivery and hospital services—In-Network:** You pay $100, then Plan pays 100% **Out-of-Network:** You pay 40%, Plan pays 60%
Alternative Care Acupuncture, chiropractic and massage therapy	Plan pays 100% after copay **Acupuncture:** $10/visit up to 24 visits/calendar year **Chiropractic:** $10/visit up to 30 visits/calendar year **Massage:** $25/visit up to 12 visits/calendar year	Plan pays 100% after copay **Acupuncture:** $15/visit up to 9 visits/calendar year **Chiropractic:** $15/visit up to 12 visits/calendar year **Massage:** Not covered	Plan pays 100% after employee cost share up to 4 visits/calendar year **Acupuncture—In-Network:** $25/visit **Chiropractic—In-Network:** $25/visit **Out-of-Network:** You pay 40%, Plan pays 60% **Massage:** Not covered
Telehealth / Virtual Visits Phone and video consultations	You pay $0; Plan pays 100%	You pay $0; Plan pays 100%	**In-Network:** You pay $0, Plan pays 100% **Out-of-Network:** Not covered
Urgent Care	You pay $10 copay/visit; then the Plan pays 100%	You pay $10 copay/visit; then the Plan pays 100%	**In-Network:** You pay $10 copay, then Plan pays 100% **Out-of-Network:** You pay 40%, Plan pays 60%
Emergency Care (Copay waived if admitted)	You pay 10%; Plan pays 90%	You pay $100 copay, then the Plan pays 100%	You pay $100 copay, then the Plan pays 100%
Hospital (Inpatient)	You pay 0%; Plan pays 100%	You pay 0%; Plan pays 100%	**In-Network:** You pay $0, Plan pays 100% **Out-of-Network:** You pay 40%, Plan pays 60%
Ambulatory Surgery Center	You pay 0%; Plan pays 100%	You pay $0; Plan pays 100%	**In-Network:** You pay $0, Plan pays 100% **Out-of-Network:** You pay 40%, Plan pays 60%
Outpatient Surgery	You pay 0%; Plan pays 100%	You pay 0%; Plan pays 100%	**In-Network:** You pay $0, Plan pays 100% **Out-of-Network:** You pay 40%, Plan pays 60%

*No out-of-network coverage except urgent or emergency care while traveling.
**No out-of-network coverage except emergency care

Chart continued on next page

This is an overview of commonly used services. For benefit details, go to **sdtrust.com**. If there is a conflict between this chart 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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	Kaiser Permanente*	Providence In-Network Only Plan**	Providence PPO Plan
Mental Health / Substance Abuse	**Inpatient:** You pay 0%; Plan pays 100% **Outpatient:** You pay $10 copay ($0 for pediatric); then Plan pays 100%	**Inpatient:** You pay $0 Plan pays 100% **Outpatient:** You pay $10 copay; then Plan pays 100%	**Inpatient—In-Network:** You pay $0, Plan pays 100% **Out-of-Network:** You pay 40%, Plan pays 60% **Outpatient—In-Network:** You pay $10 copay, then Plan pays 100% **Out-of-Network:** You pay 40%, Plan pays 60%
Routine Hearing Exams/Tests	You pay $10 copay; then the Plan pays 100%	You pay $10 copay; then the Plan pays 100%	**In-Network:** You pay $10 copay, then the Plan pays 100% **Out-of-Network:** You pay 40%, Plan pays 60%
Hearing Aids (Adult)	Plan pays $500/ear every 3 years	One hearing aid per ear every 3 years You pay 0%; Plan pays 100%	One hearing aid per ear every 3 years **In-Network:** You pay $0, Plan pays 100% **Out-of-Network:** You pay 40%, Plan pays 60%
Out of Area Dependent Coverage	Limited services	Full services; requires annual enrollment	
Coverage While Traveling	World-wide urgent/ emergency care coverage Routine care available in other KP service areas	World-wide urgent/emergency care coverage Nationwide in-network coverage	

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Prescription Drug Benefits Overview

	Kaiser Permanente Prescription Drug Plan	Trust Prescription Drug Plan (administered by Express Scripts) For members enrolled in a Providence medical plan
In-network/Participating Pharmacies	Kaiser Permanente	Use Express-Scripts
Participating Pharmacy Benefits	Plan pays 100% after your copay: **Generic:** $5/30 day supply **Brand name:** $10/30 day supply	Plan pays 100% after your copay: **Generic:** $10/$20/$30 per 34/68/90-day supply **Brand name:** $20/$40/$60 per 34/68/90-day supply
Non-Participating Pharmacy Benefits	Generally not covered	You pay the full amount, then submit a claim for reimbursement
Mail-order Service Benefits	Plan pays 100% after your copay: **Generic:** $10/90-day supply **Brand name**: $20/90-day supply	Plan pays 100% after your copay: **Generic**: $20/90-day supply **Brand name**: $40/90-day supply

Vision Benefits Overview

	Kaiser Permanente	Trust Vision Plan (administered by VSP) For members enrolled in a Providence medical plan
Well Vision Exam	You pay $10 copay per exam; then Plan pays 100%	Every 12 months **VSP Provider**: 100% **Other Provider**: Up to $70
Contact Lens Exam (Fitting and Evaluation)	You pay $30 contact fitting fee	Every 12 months **VSP Provider**: Not to exceed $60 copay per exam **Other Provider**: Combined with contacts
Frames	$250 credit every 24 months towards frames, lenses and contacts	Every 24 months **VSP Provider**: Up to $150 allowance and 20% off amount over allowance **Other Provider**: Up to $75
Lenses	Included in $250 credit	Every 12 months **VSP Provider**: 100% for most lens types **Other Provider**: Up to $50-$100 for most lens types
Contacts Instead of Glasses	Included in $250 credit	Every 12 months **VSP Provider**: Up to $150 for contacts **Other Provider**: Up to $137 for fitting, evaluation and contacts

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Dental Benefits Overview

	Kaiser Permanente Dental	Trust Dental Plan/Delta Dental of Oregon
Diagnostic and Preventive Care (exams, cleaning, X-rays)	Plan pays 100% of UCR	Plan pays 100%
Basic and Restorative Services	You pay 20%; Plan pays 80% of UCR	You pay 20%; Plan pays 80%
Major Services	You pay 50%; Plan pays 50% of UCR	You pay 50%; Plan pays 50%
Orthodontia	Plan pays 50% up to $4,000 maximum lifetime benefit per person	Plan pays 50% up to $4,000 maximum lifetime benefit per person
Maximum Annual Benefit	$2,500	$2,500

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