RATES

ATU TYPE 10 DRIVERS—APRIL 1–SEPTEMBER 30, 2025

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

MONTHLY CONTRIBUTION RATES			
Plan Name	**Kaiser Permanente Plan**	**Providence In-Network Only Plan**	**Providence PPO Plan**
Includes Kaiser Dental Plan			
Member Only	$86.96	$147.44	$171.26
Member + one dependent	$947.30	$1,074.70	$1,122.38
Member + Family	$1,593.08	$2,002.12	$2,073.60
Includes Trust Dental Plan (Delta Dental of Oregon)			
Member Only	$93.96	$154.44	$178.26
Member + one dependent	$960.48	$1,087.88	$1,135.56
Member + Family	$1,615.88	$2,024.92	$2,096.40

Continued on next page

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.

RATES

ATU TYPE 10 DRIVERS—APRIL 1–SEPTEMBER 30, 2025

ATU

MEDICAL/Rx/VISION PLANS—COVERAGE AND COSTS	Choose One of These Plans*		
Plan Name	**Kaiser Permanente Plan**	**Providence In-Network Only Plan**	**Providence PPO 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 this network: • Kaiser Permanente: **kp.org**	Choose a provider in the Providence PPS/SD-1 Trust network: **myProvidence.com**	Choose any provider, but save money when you choose a provider in the Providence PPS/SD-1 Trust network: **myProvidence.com**
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	$200/individual $600/family	$200/individual $400/family	$200/individual $400/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.

DENTAL PLANS—COVERAGE AND COSTS	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.