

BENEFITS OVERVIEW

PAT EARLY RETIREES—2024 PLAN YEAR



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Medical Benefits Overview

	Kaiser Permanente Plan*	Providence PAT Retiree In-Network Only**	Providence PAT Retiree Trust Plan 2	Closed to New Enrollment Providence PAT Retiree Trust Plan 1
Office Visits*** Primary, naturopathic and behavioral health care, and substance use disorders	You pay \$5 copay/visit; then the Plan pays 100%	You pay \$5 copay/visit; then the Plan pays 100%	In-network: You pay \$5 copay/visit for up to 3 primary or naturopathic care visits/person and up to 3 behavioral health or substance use disorder visits/person; then you pay 10%; Plan pays 90% Out-of-network: You pay 30%; Plan pays 70% of allowable expense	In-network: You pay \$5 copay/visit for up to 3 primary or naturopathic care visits/person and up to 3 behavioral health or substance use disorder visits/person; then you pay 15%; Plan pays 85% Out-of-network: You pay 25%; Plan pays 75% of allowable expense
Preventive Health Exams and Services (Frequency schedule applies)	You pay \$0; Plan pays 100%	You pay \$0; Plan pays 100%	You pay \$0; Plan pays 100% (deductible waived)	You pay \$0; Plan pays 100% (deductible waived)
Labs and X-rays	You pay \$0; Plan pays 100%	You pay \$0; Plan pays 100%	In-network: You pay 10%; Plan pays 90% Out-of-network: You pay 30%; Plan pays 70%	In-network: You pay 15%; Plan pays 85% Out-of-network: You pay 25%; Plan pays 75%
Maternity Care	You pay 10%; the Plan pays 90%	You pay \$0; Plan pays 100%	In-network: You pay 10%; Plan pays 90% Out-of-network: You pay 30%; Plan pays 70%	In-network: You pay 15%; Plan pays 85% Out-of-network: You pay 25%; Plan pays 75%
Alternative Care Acupuncture, chiropractic and massage therapy	Plan pays 100% after copay Acupuncture: \$10/visit up to 24 visits/year Chiropractic: \$10/visit up to 30 visits/year Massage: \$25/visit up to 12 visits/year	Acupuncture: You pay \$10 copay/visit; then Plan pays 100%, up to 20 visits/year Chiropractic: Not covered Massage: Not covered	In-network: You pay 10%; Plan pays 90% Out-of-network: You pay 30%; Plan pays 70% Massage: Not covered	In-network: You pay 15%; Plan pays 85% Out-of-network: You pay 25%; Plan pays 75% Massage: Not covered
Telehealth/Virtual Visits*** Phone and video consultations	You pay \$0; Plan pays 100% (includes email)	You pay \$0; Plan pays 100%	You pay \$5 copay/visit for up to 3 primary, naturopathic or specialty care visits/person and up to 3 behavioral health or substance use disorder visits/person; then you pay 10%; Plan pays 90%	You pay \$5 copay/visit for up to 3 primary, naturopathic or specialty care visits/person and up to 3 behavioral health or substance use disorder visits/person; then you pay 15%; Plan pays 85%
Urgent Care	You pay \$5 copay/visit; then the Plan pays 100%	You pay \$5 copay/visit; then the Plan pays 100%	In-network: You pay 10%; Plan pays 90% Out-of-network: You pay 30%; Plan pays 70%	In-network: You pay 15%; Plan pays 85% Out-of-network: You pay 25%; Plan pays 75%
Emergency Care	You pay \$25 copay/visit (waived if admitted); Plan pays 100%	You pay \$50 copay (waived if admitted); then the Plan pays 100%	You pay \$25 copay (waived if admitted); then you pay 10%; Plan pays 90%	You pay 15%; Plan pays 85% (deductible does not apply)
Hospital (Inpatient)	You pay \$0; Plan pays 100%	You pay \$0; Plan pays 100%	In-network: You pay 10%; Plan pays 90% Out-of-network: You pay 30%; Plan pays 70%	In-network: You pay 15%; Plan pays 85% Out-of-network: You pay 25%; Plan pays 75%
Ambulatory Surgery Center	You pay \$5 copay/visit; then the Plan pays 100%	You pay \$0; Plan pays 100%	In-network: You pay 10%; Plan pays 90% Out-of-network: You pay 30%; Plan pays 70%	In-network: You pay 10%; Plan pays 90% Out-of-network: You pay 25%; Plan pays 75%
Outpatient Surgery	You pay \$5 copay/visit; then the Plan pays 100%	You pay \$0; Plan pays 100%	In-network: You pay 10%; Plan pays 90% Out-of-network: You pay 30%; Plan pays 70%	In-network: You pay 15%; Plan pays 85% Out-of-network: You pay 25%; Plan pays 75%
Inpatient Mental Health/Substance Use Disorders	You pay \$0; Plan pays 100%	You pay \$0; Plan pays 100%	In-network: You pay 10%; Plan pays 90% Out-of-network: You pay 30%; Plan pays 70%	In-network: You pay 15%; Plan pays 85% Out-of-network: You pay 25%; Plan pays 75%
Routine Hearing Exams/Tests	You pay \$5 copay; then the Plan pays 100%	You pay \$5 copay; then the Plan pays 100%	Not covered	Not covered
Hearing Aids (Adult)	Not covered	You pay 20%; Plan pays 80%	In-network: You pay 10%; Plan pays 90% Out-of-network: You pay 30%; Plan pays 70%	In-network: You pay 15%; Plan pays 85% Out-of-network: You pay 25%; Plan pays 75%
Out of Area Dependent Coverage	Limited services	Full services	Full services; requires annual enrollment	Full services; requires annual enrollment
Coverage While Traveling	Worldwide urgent/emergency care coverage. Routine care is available in KP service areas.	Worldwide urgent/emergency care coverage. Nationwide in-network coverage	Nationwide network of providers	Nationwide network of providers

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

**No out-of-network coverage except emergency care.

***Virtual care visits count towards the first three office visits.

This is an overview of commonly used services. For medical 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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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	
		Providence PAT Retiree In-Network Only Plan	Providence PAT Retiree Trust Plans 1 and 2 (Plan 1 closed to new enrollment)
In-Network / Participating Pharmacies	Kaiser Permanente	Express Scripts	Express Scripts
Preventive	Match generic	Match generic	You pay \$0 for certain preventive drugs
Participating Pharmacy Benefits	You pay 50% up to \$50; Plan pays remainder. Per 30-day supply	*You pay 50% up to \$50; Plan pays remainder. Per 30-day supply	You pay 20%; Plan pays 80% Up to 90-day supply
Non-Participating Pharmacy Benefits	Generally not covered	You pay the full amount, then submit a claim for reimbursement	You pay the full amount, then submit a claim for reimbursement
Mail-Order Service Benefits	You pay 50% up to \$100; Plan pays remainder. Up to 90-day supply	*You pay 50% up to \$100; Plan pays remainder. Up to 90-day supply	You pay 20%; Plan pays 80% Up to 90-day supply

*You also pay the difference in cost for the brand-name drug if a generic drug is available.

Optional Dental Benefits Overview

Kaiser Dental or Trust Dental Plan/Delta Dental of Oregon	Basic Dental	Buy-Up Dental
Diagnostic and Preventive Care (exams, cleanings, X-rays)	You pay 20%; Plan pays 80%	You pay \$0; Plan pays 100%
Basic Services (fillings, extractions, minor oral surgery)	You pay 20%; Plan pays 80%	You pay 20%; Plan pays 80%
Restorative Services (onlays, crowns)	You pay 50%; Plan pays 50%	You pay 20%; Plan pays 80%
Major Services (bridges, dentures)	You pay 50%; Plan pays 50%	You pay 50%; Plan pays 50%
Orthodontia	Not covered	You pay 50%; Plan pays 50%, up to \$4,000/person lifetime benefit maximum
Maximum Annual Benefit	\$1,200	\$2,500

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Optional Vision Benefits Overview

	Kaiser Permanente Vision Plan	Trust Vision Plan (administered by VSP) For members enrolled in a Providence medical plan
Basic Vision Plan: Every 24 months		
Well Vision Exam	You pay \$25 copay per exam; then Plan pays 100%	VSP Provider: You pay \$25 copay; then the Plan pays 100% Other Provider: You pay \$25 copay; then Plan pays up to \$45
Contact Lens Exam (Fitting and Evaluation)	You pay \$30 contact fitting fee	VSP Provider: Not to exceed \$60 per exam Other Provider: Combined with contact lenses
Frames	Included in \$100 credit	VSP Provider: Plan pays up to \$150 Other Provider: Plan pays up to \$47
Lenses	Included in \$100 credit	VSP Provider: You pay \$25 copay; then Plan pays single vision, lined bifocal or lined trifocal lenses Other Provider: Plan pays up to \$45 single vision, \$65 lined bifocal or \$85 lined trifocal
Contact Lenses instead of glasses	Included in \$100 credit	VSP Provider: Plan pays up to \$150 Other Provider: Plan pays up to \$105 for contacts and contact lens exam (combined)
Buy-Up Vision Plan		
Well Vision Exam	N/A	VSP Provider (every 12 months): You pay \$0; Plan pays 100% Other Provider: Plan pays up to \$70
Contact Lens Exam (Fitting and Evaluation)	N/A	VSP Provider: Not to exceed \$60 per exam Other Provider: Combined with contact lenses
Frames	N/A	VSP Provider (every 24 months): Plan pays up to \$150 Other Provider: Plan pays up to \$75
Lenses	N/A	VSP Provider (every 12 months): Plan pays single vision, lined bifocal, or lined bifocal in full Other Provider: Plan pays up to \$50 Single Vision, \$75 Lined Bifocal or \$100 Lined Trifocal
Contact Lenses instead of glasses	N/A	VSP Provider: Every 12 months: Plan pays up to \$150 Other Provider: Plan pays up to \$137 for contact lenses and contact lens exam (combined)
Vision Therapy (if qualified)	N/A	VSP Provider: 100% for evaluation; 75% for approved therapy up to \$750/year Other Provider: Up to \$85 for evaluation; 75% for approved therapy up to \$750/year

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