

# RATES

## PAT EARLY RETIREES—2024 PLAN YEAR



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### Medical and Prescription Plans

Plan Name	Choose One of These Health Plans			Closed to New Enrollment
	Kaiser Permanente Plan	Providence PAT Retiree In-Network Only	Providence PAT Retiree Trust Plan 2	Providence PAT Retiree Trust Plan 1
<b>Monthly Contribution Rates—Self-Pay</b>				
<b>Retiree only</b>	\$772.30	\$835.02	\$736.24	\$856.92
<b>Retiree + one</b>	\$1,417.96	\$1,650.74	\$1,474.84	\$1,722.34
<b>Retiree + family</b>	\$1,904.92	\$2,443.02	\$2,107.86	\$2,464.10
<b>Monthly Contribution Rates—with District Contribution*</b>				
<b>Retiree only<sup>1</sup></b>	\$0	\$0	\$0	\$0
<b>Retiree + spouse/ domestic partner<sup>1</sup></b>	\$347.82	\$407.86	\$369.30	\$432.70
<b>Retiree + spouse/ domestic partner and child(ren)<sup>1</sup></b>	\$834.78	\$1,200.14	\$1,002.32	\$1,174.46
<b>Retiree + one child<sup>2</sup></b>	\$695.66	\$815.72	\$738.60	\$865.42
<b>Retiree + two or more children<sup>2</sup></b>	\$1,182.62	\$1,608.00	\$1,371.62	\$1,607.18

\* District-paid contribution for 60 months immediately following retirement, then eligible for self-pay. Includes 50% District-paid contribution for spouse/ domestic partner if enrolled. <sup>2</sup> District-paid contribution for member only for 60 months immediately following retirement, then eligible for self-pay.

Chart continued on next page

This is an overview of commonly used services. For additional Plan comparisons, go to [sdtrust.com](http://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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PAT

Plan Name	Choose One of These Health Plans			Closed to New Enrollment
	Kaiser Permanente Plan	Providence PAT Retiree In-Network Only	Providence PAT Retiree Trust Plan 2	Providence PAT Retiree Trust Plan 1
<b>Medical</b>				
<b>How the Plan Pays Benefits</b>	The Plan pays 100% of most covered services after you pay the copay. <b>No out-of-network coverage except emergency care and urgent care when traveling.</b>	The Plan pays 100% of most covered services after you pay the copay/coinsurance. <b>No out-of-network coverage except emergency care.</b>	After you pay the deductible: The Plan pays 90% of most covered services when you choose a Providence In-network Provider.  Plan pays 70% of most covered services when you choose a provider outside the Providence network—plus you pay any amount billed over the allowed amount.	After you pay the deductible: The Plan pays 85% of most covered services when you choose a Providence In-network Provider.  Plan pays 75% of most covered services when you choose a provider outside the Providence network—plus you pay any amount billed over the allowed amount.
<b>Provider Choices</b>	Choose providers in these networks: • Kaiser Permanente: <a href="http://kp.org">kp.org</a> • The Portland Clinic: <a href="http://theportlandclinic.com">theportlandclinic.com</a>	Choose a provider in the Providence PPS/SD-1 Trust network: <a href="http://myProvidence.com">myProvidence.com</a>	You may choose any provider, but your out-of-pocket costs will be lower when you choose a provider in the Providence PPS/SD-1 Trust network: <a href="http://myProvidence.com">myProvidence.com</a>	You may choose any provider, but your out-of-pocket costs will be lower when you choose a provider in the Providence PPS/SD-1 Trust network: <a href="http://myProvidence.com">myProvidence.com</a>
<b>Prescription</b>	<b>Kaiser Permanente Plan</b>	<b>Trust Prescription Drug Plan (administered by Express Scripts) For members enrolled in a Providence medical plan</b>		
<b>Retail and Mail Order Available</b>	Use Kaiser Permanente pharmacies and mail order	Use Express Scripts network pharmacies and mail order		
<b>Your Costs</b>				
<b>Annual Medical Plan Deductible</b>	\$0	\$0	\$200/person, \$400/family	\$200/person, \$400/family
<b>Annual Medical Plan Out-of-Pocket Maximum</b>	\$600/person, \$1,200/family	\$700/person, \$2,000/family	<b>In-network:</b> \$1,000/person, \$14,000/family <b>Out-of-network:</b> \$3,000/person, unlimited/family	<b>Preferred:</b> \$1,000/person up to \$14,000
<b>Annual Prescription Drug Plan Out-of-Pocket Maximum</b>	N/A	\$2,200/person, \$4,400/family	Prescription expenses apply to medical out-of-pocket maximum	Prescription expenses apply to medical out-of-pocket maximum

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### Optional, Self-Pay Dental and Vision Plans

You must be enrolled in a Medical Plan to enroll in the self-pay, optional Dental and Vision Plan coverage. Dental and Vision cannot be purchased separately.

RATES	Kaiser Medical* Plan with <i>Kaiser Vision</i> and <i>Kaiser Dental</i> Plans	Kaiser Medical* Plan with <i>Kaiser Vision</i> and <i>Trust Dental</i> Plans	Providence Medical Plan with <i>Trust Vision</i> and <i>Kaiser Dental</i> Plans	Providence Medical Plan with <i>Trust Vision</i> and <i>Trust Dental</i> Plans
<b>Monthly Contributions—Basic Coverage</b>				
<b>Retiree only</b>	\$40.30	\$34.08	\$44.40	\$38.18
<b>Retiree + one</b>	\$75.68	\$63.98	\$83.86	\$72.16
<b>Retiree + family</b>	\$130.66	\$110.54	\$140.02	\$119.90
<b>Monthly Contributions—Buy-Up Coverage</b>				
<b>Retiree only</b>	\$58.48	\$62.90	\$65.20	\$69.62
<b>Retiree + one</b>	\$109.82	\$118.16	\$123.24	\$131.58
<b>Retiree + family</b>	\$189.62	\$204.06	\$205.00	\$219.44

\*If you are enrolled in the Kaiser Medical/Prescription Plan, vision coverage is included in that Plan. Monthly contribution rates are for optional, self-pay Dental only.

VISION	Kaiser Permanente Plan	Trust Vision Plan (administered by VSP) For members enrolled in a Providence medical plan
<b>Provider Choice</b>	Use Kaiser Permanente providers No out-of-network coverage	Use any provider but save money if you use a VSP provider

DENTAL	Choose One of These Plans	
	Kaiser Permanente Dental	Trust Dental Plan (administered by Delta Dental of Oregon)
<b>Provider Choice</b>	Use Kaiser Permanente providers No out-of-network coverage	Use any provider; save money with an in-network provider
<b>Your Costs</b>		
<b>Annual Dental Deductible</b>	<b>Basic:</b> \$50/person <b>Buy Up:</b> \$0	<b>Basic:</b> \$50/person <b>Buy Up:</b> \$0
<b>Dental Maximum Annual Benefit</b>	<b>Basic:</b> \$1,200 <b>Buy Up:</b> \$2,500	<b>Basic:</b> \$1,200 <b>Buy Up:</b> \$2,500



Consider your choice for Dental coverage carefully: You will not be able to change your choice in the future.

If you enroll and then decline coverage later, you cannot re-enroll in the future.

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