

BENEFITS OVERVIEW

PAT ACTIVES—2021 PLAN YEAR

PAT



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Medical Benefits Overview

	Kaiser Permanente (Option 1 & 2)	Providence Personal Option Plan (Option 1 & 2)
Office Visits for primary or specialty care	You pay \$5 copay/visit (\$0 pediatric primary care); then the Plan pays 100%	You pay \$10 copay/visit; then the Plan pays 100%
Preventive Health Exams and Well-Baby Care (Frequency schedule applies)	You pay \$0; Plan pays 100%	You pay \$0; Plan pays 100%
Labs and X-rays	You pay \$0; Plan pays 100%	You pay 10%; Plan pays 90%
Maternity Care	You pay \$0; Plan pays 100%	Pre- and post-natal: You pay \$0; Plan pays 100% Delivery and hospital services: You pay 10%; Plan pays 90%
Alternative Care Acupuncture, chiropractic, naturopathy and massage therapy	Acupuncture, chiropractic and naturopathy: You pay \$10 copay/visit; then the Plan pays 100% Massage therapy: You pay \$25/visit; then the Plan pays 100% up to 12 visits/calendar year \$1,500/year max benefit combined for all alternative care	You pay \$10 copay/visit; then the Plan pays 100% (up to 20 visits/calendar year; unlimited naturopathy). Massage therapy not covered.
Telehealth/Virtual Visits Phone and video consultations	Plan pays 100%	Plan pays 100% when you use Providence Express Care Virtual
Urgent Care	You pay \$5 copay/visit; then the Plan pays 100%	You pay \$10 copay/visit; then the Plan pays 100%
Emergency Care	You pay \$25 copay/visit; Plan pays 100% (copay waived if admitted)	You pay \$100 copay/visit; then the Plan pays 100% (copay waived if admitted; all services are subject to inpatient benefits)
Hospital (Inpatient)	You pay \$0; Plan pays 100%	You pay 10%; Plan pays 90%
Ambulatory Surgery Center	You pay \$5 copay/visit; then the Plan pays 100%	You pay \$0; Plan pays 100%
Outpatient Surgery	You pay \$5 copay/visit; then the Plan pays 100%	You pay \$0; Plan pays 100%
Mental Health / Substance Abuse	Inpatient: You pay \$0; Plan pays 100% Outpatient: You pay \$5 copay/visit (\$0 for pediatric); Plan pays 100%	Inpatient: You pay 10%; Plan pays 90% Outpatient: You pay \$10 copay/visit; Plan pays \$100
Routine Hearing Exams/Tests	You pay \$5 copay/visit; then the Plan pays 100%	You pay \$10 copay/visit; then the Plan pays 100%
Hearing Aids (Adult)	Plan pays \$500/ear every 3 years Option 2: Adult hearing aids are not covered	You pay 20%; plan pays 80%
Out of Area Dependent Coverage	Limited services; requires annual enrollment	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

Chart continued on next page

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	Regence Preferred Provider Plan (Option 1)	Regence Indemnity Plan (Option 2)
Office Visits for primary or specialty care	Preferred: You pay 20%; Plan pays 80% Participating and Nonparticipating: You pay 30%; Plan pays 70%	You pay 20%; Plan pays 80%
Preventive Health Exams and Well-Baby Care (Frequency schedule applies)	Preferred and Participating: You pay \$0; Plan pays 100% (deductible waived) Nonparticipating: You pay 30%; Plan pays 70%	You pay \$0; Plan pays 100% (deductible waived)
Labs and X-rays	Preferred and Participating: You pay 20%; Plan pays 80% Nonparticipating: You pay 30%; Plan pays 70%	You pay 20%; Plan pays 80%
Maternity Care	Preferred: You pay 20%; Plan pays 80% Participating and Nonparticipating: You pay 30%; Plan pays 70%	You pay 20%; Plan pays 80%
Alternative Care Acupuncture, chiropractic and naturopathy (Massage therapy not covered)	Preferred, Participating and Nonparticipating: You pay 20%; Plan pays 80%	You pay 20%; Plan pays 80%
Telehealth/Virtual Visits Phone and video consultations	Preferred and Participating: You pay 20%; Plan pays 80%. Nonparticipating: You pay 30%; Plan pays 70%	You pay 20%; Plan pays 80%
Urgent Care	Preferred: You pay 20%; Plan pays 80% Participating and Nonparticipating: You pay 30%; Plan pays 70%	You pay 20%; Plan pays 80%
Emergency Care	Any Provider: You pay \$100 copay/visit; then Plan pays 100%, no deductible required (copay waived if admitted)	You pay 20%; Plan pays 80%
Hospital (Inpatient)	Preferred: You pay 20%; Plan pays 80% Participating and Nonparticipating: You pay 30%; Plan pays 70%	You pay 20%; Plan pays 80%
Ambulatory Surgery Center	Preferred: You pay 10%; Plan pays 90% Non-preferred: You pay 30%; Plan pays 70%	Preferred: You pay 10%; Plan pays 90% Non-preferred: You pay 20%; Plan pays 80%
Outpatient Surgery	Preferred: You pay 20%; Plan pays 80% Non-preferred: You pay 30%; Plan pays 70%	You pay 20%; Plan pays 80%
Mental Health / Substance Abuse	Preferred and Participating: You pay 20%; Plan pays 80% Nonparticipating: You pay 30%; Plan pays 70% (Deductible does not apply to outpatient.)	You pay 20%; Plan pays 80% (Deductible does not apply to outpatient.)
Routine Hearing Exams/Tests	Not covered	Not covered
Hearing Aids	Preferred: You pay 10%; Plan pays 90% Participating and Non-Participating: You pay 30%; Plan pays 70%	You pay 20%; Plan pays 80%
Out of Area Dependent Coverage	Full services through Blue Card program	Full services through Blue Care program.
Coverage While Traveling	Blue Card Program	Blue Card Program

For details and rates, go to sdtrust.com. 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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Prescription Drug Benefits Overview

	Kaiser Permanente Prescription Drug Plan (Option 1 & 2)	Providence Personal Option and Regence Preferred Provider Option 1 Plans Trust Prescription Drug Plan	Providence Personal Option Plan and Regence Trust Indemnity Option 2 Plans Trust Prescription Drug 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	Plan pays 100% after your copay: Generic: \$5/\$10/\$15 per 30/60/90-day supply Brand name: \$10/\$20/\$30 per 34/68/90-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	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	Plan pays 100% after your copay: Generic: \$5/90-day supply Brand name: \$10/90-day supply

Vision Benefits Overview

OPTION 1 PLANS ONLY	Kaiser Permanente	Providence Personal Option Plan	Regence Trust Preferred Provider Plan
		Trust Vision Plan administered by VSP	
Well Vision Exam	You pay \$5 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	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 Other Provider: Up to \$70	
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 \$60 copay for fitting and evaluation; up to \$150 for contacts Other Provider: Up to \$137	

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Dental Benefits Overview

OPTION 1 PLANS ONLY	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

Term Life and Accidental Death & Dismemberment Benefits Overview

ALL PLANS—Option 1 and 2	Life Insurance	AD&D Insurance
Provided by The Trust	Basic Term Life \$50,000 per member	Basic AD&D Up to \$50,000 per member
You may purchase coverage for yourself and eligible covered dependents. You must purchase Optional Life and Voluntary AD&D for yourself in order to buy coverage for your dependents. Coverage may be subject to medical underwriting approval. You can find the Enrollment Guide and a needs calculator on sdtrust.com .	Optional Life; Employee and Spouse: \$10,000 to \$500,000 in \$10,000 increments not to exceed 5 times annual salary Child(ren): \$2,000 to \$10,000 in \$2,000 increments	Voluntary AD&D Employee: \$25,000 to \$300,000 in \$25,000 increments Spouse: 50% of your selected coverage Child(ren) Only: 15% of your AD&D coverage amount for each child up to \$25,000 Spouse and Child(ren): 40% of your selected coverage for your spouse and 10% of your selected coverage (up to \$25,000) per child

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Long Term Disability Overview

ALL PLANS—Option 1 and 2	Coverage
All eligible employees are automatically enrolled for self-pay Long-Term Disability benefits, without the option to decline, regardless of enrollment for healthcare benefits.	Plan pays 60% of your pre-disability earnings, up to \$6,000/month, if you become disabled as a result of a covered injury, sickness or pregnancy.

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