BENEFITS OVERVIEW

PAT EARLY RETIREES—2023 PLAN YEAR

HEALTH & WELFARE TRUST
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PAT

IMPORTANT: Beginning April, 1, 2023, the PAT Retiree In-Network Only Plan, Trust Plan 1 and Trust Plan 2 are administered by Providence and the provider network is the Providence PPS/SD-1 Trust network.

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 for primary, naturopathy or specialty care	You pay $5 copay/visit ($0 for pediatric primary care); 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% of allowable expense	**In-network:** 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 10%; Plan pays 90%	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	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%
Mental Health/Substance Use Disorders	**Inpatient:** You pay $0; Plan pays 100% **Outpatient:** You pay $5 copay/visit; then the Plan pays 100%	**Inpatient:** You pay $0; Plan pays 100% **Outpatient:** 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% **Outpatient:** deductible does not apply	**In-network:** You pay 15%; Plan pays 85% **Out-of-network:** You pay 25%; Plan pays 75% **Outpatient:** deductible does not apply
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.

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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

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 Play 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

This is an overview of commonly used services. For benefit details, 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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