BENEFITS OVERVIEW

PFSP, ATU AND DCU EARLY RETIREES—2023 PLAN YEAR

PFSP ATU DCU

Health & Welfare Trust
School District No.1

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

Medical Benefits Overview

	Kaiser Permanente Plan*	Providence PDA PPO Retiree	Providence PDA Retiree In-Network Only**
Office Visits for primary, naturopathy or specialty care	You pay $20 copay/visit ($0 for pediatric primary care); then the Plan pays 100%	**In-Network**: You pay $20 copay/visit; then the Plan pays 100% **Out-of-Network**: You pay 40%; Plan pays 60%	You pay $20 copay/visit; then the Plan pays 100%
Preventive Health Exams and Services (Frequency schedule applies)	You pay $0; Plan pays 100%	**In-Network**: You pay $0; Plan pays 100% **Out-of-Network**: You pay 40%; Plan pays 60%	You pay $0; Plan pays 100%
Labs and X-rays	You pay $0; Plan pays 100%	**In-Network**: You pay 20%; Plan pays 80% **Out-of-Network**: You pay 40%; Plan pays 60%	You pay 10%; Plan pays 90%
Maternity Care	**Pre- and Post-Natal Care:** You pay $0; Plan pays 100% **Delivery & Hospital Services:** You pay 10%; Plan pays 90%	**Pre- and Post-Natal Care—In-Network:** You pay $0; Plan pays 100%; **Out-of-Network**: You pay 40%; Plan pays 60% **Delivery & Hospital Services:** You pay $200 copay/delivery; then the Plan pays 100%. **Out-of-Network**: You pay 40%; Plan pays 60%	**Pre and Post Natal Care:** You pay $0; Plan pays 100% **Delivery & Hospital Services:** You pay $200 copay/delivery; then the Plan pays 100%
Alternative Care Acupuncture, chiropractic, and massage therapy (not covered under Providence plans)	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:** $20 copay/visit; then Plan pays 100% up to 4 visits/year; no out-of-network **Chiropractic:** $20 copay/visit; then Plan pays 100% up to 4 visits/year; no out-of-network	**Acupuncture:** $20 copay/visit; then Plan pays 100% up to 9 visits/year; no out-of-network **Chiropractic:** $20 copay/visit; then Plan pays 100% up to 12 visits/year; no out-of-network
Telehealth/Virtual Visits Phone and video consultations	You pay $0; Plan pays 100% (includes email)	Plan pays 100%	Plan pays 100%
Urgent Care	You pay $20 copay; then the Plan pays 100% Within service area, you must use Kaiser facility or Portland Clinic	**In-Network**: You pay $20 copay; then the Plan pays 100% **Out-of-Network**: You pay 40%; Plan pays 60%	You pay $20 copay/visit; then the Plan pays 100%
Emergency Care	Kaiser or non-Kaiser facility: You pay 10%; Plan pays 90%	**In-Network** or **Out-of-Network**: You pay $100 copay; then the Plan pays 100%	**In-Network** or **Out-of-Network**: You pay $100 copay; then the Plan pays 100%
Hospital (Inpatient)	You pay 10%; Plan pays 90%	**In-Network**: You pay 20%; Plan pays 80% **Out-of-Network**: You pay 40%; Plan pays 60%	You pay 10%; Plan pays 90%

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

Chart continued on next page

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PFSP, ATU AND DCU EARLY RETIREES—2023 PLAN YEAR

PFSP ATU DCU

	Kaiser Permanente Plan*	Providence PDA PPO Retiree	Providence PDA Retiree In-Network Only**
Ambulatory Surgery Center	You pay 10%; Plan pays 90%	**In-Network**: You pay 20%; Plan pays 80% **Out-of-Network**: You pay 40%; Plan pays 60%	You pay 10%; Plan pays 90%
Outpatient	You pay 10%; Plan pays 90%	**In-Network**: You pay 20%; Plan pays 80% **Out-of-Network**: You pay 40%; Plan pays 60%	You pay 10%; Plan pays 90%
Mental Health/Substance Use Disorders	**Outpatient**: You pay $20 copay/visit; then the Plan pays 100% **Inpatient**: You pay 10%; Plan pays 90%	**Outpatient**—**In-Network**: You pay $20 copay/visit; then the Plan pays 100%; **Out-of-Network**: You pay 40%; Plan pays 60% **Inpatient**—**In-Network**: You pay 20%; Plan pays 80%; **Out-of-Network**: You pay 40%; Plan pays 60%	**Outpatient**: You pay $20 copay/visit; then the Plan pays 100% **Inpatient**: You pay 10%; Plan pays 90%
Routine Hearing Exams/Tests	You pay $20 copay/visit; then the Plan pays 100%	**In-Network**: You pay $20 copay; then the Plan pays 100% **Out-of-Network**: You pay 40%; Plan pays 60%	You pay $20 copay; then the Plan pays 100%
Hearing Aids (Adult)	Not covered	**In-Network**: You pay 20%; Plan pays 80% **Out-of-Network**: You pay 40%; Plan pays 60%	You pay 10%; Plan pays 90%
Out of Area Dependent Coverage	Limited services	Full services; requires annual enrollment	
Coverage While Traveling	Worldwide urgent/emergency care coverage Routine care is available in KP service areas.	World-wide urgent/emergency care coverage Nationwide in-network coverage	

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

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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PFSP, ATU AND DCU EARLY RETIREES—2023 PLAN YEAR

PFSP ATU DCU

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
In-Network / Participating Pharmacies	Use Kaiser Permanente Clinics	Use Express Scripts
Preventive	Match generic	Match generic
Participating Pharmacy Benefits	You pay 50% up to $50; Plan pays remainder. Up to 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
Non-Participating Pharmacy Benefits	Generally not covered	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	Plan pays 100% after your copay: **Generic:** $20 per 90-day supply **Brand name:*** $40 per 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

BENEFITS OVERVIEW

PFSP, ATU AND DCU EARLY RETIREES—2023 PLAN YEAR

PFSP ATU DCU

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

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