BENEFITS OVERVIEW

PFSP, ATU AND DCU EARLY RETIREES—2024 PLAN YEAR

PFSP ATU DCU

HEALTH & WELFARE TRUST
SCHOOL DISTRICT NO.1

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Medical Benefits Overview

	Kaiser Permanente Plan*	Providence PDA PPO Retiree	Providence PDA Retiree In-Network Only**
Office Visits*** Primary, naturopathic, and behavioral health care, and substance use disorders	You pay $5 copay/visit for up to 3 visits/person; then you pay $20 copay/visit	**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 $20 copay/visit. **Out-of-Network**: You pay 40%; Plan pays 60%	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 $20 copay/visit.
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	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 Massage therapy not covered.	**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 Massage therapy not covered.
Telehealth/Virtual Visits*** Phone and video consultations	Plan pays 100%	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%

Chart continued on next page

*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.

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	Kaiser Permanente Plan*	Providence PDA PPO Retiree	Providence PDA Retiree In-Network Only**
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%
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 Surgery	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%
Inpatient Mental Health/ Substance Use Disorders	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%
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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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

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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 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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