# SOUND HEALTH & WELLNESS TRUST

# MEDICAL, PRESCRIPTION DRUG AND VISION OPTIONS

**FOR**

# SOUND PPO PLAN (Out of Area)
# (under 36 months of employment)

# 2017 ENROLLMENT

## Sound Health & Wellness Trust

## Comparison of Medical/Prescription Drug/Vision Benefits Effective January 1, 2017

## Sound PPO Plan (under 36 months of employment)

| | Sound PPO Plan |
|---|---|
| **Prevention @ 100%** | All covered in-network preventive care is paid in full - with no deductibles, coinsurance or co-pays. |
| **Tier 0 Prescriptions** | Tier 0 is the Trust's therapeutically based prescription tier. For the highly cost-effective medications under Tier 0, there is $0 co-pay for participants. Prescriptions under Tier 0 include cholesterol lowering medications (Simvastatin), proton pump inhibitors (Omeprazole – generic of Prilosec OTC, with physician prescription), non-sedating antihistamines (Loratadine - generic of Claritin, with physician prescription), Metformin (for diabetes), and Lancets for diabetes blood testing. |
| Annual net deductible (per calendar year)<br>▪ Employee Only<br>▪ Family | <br>$300 for preferred providers<br>$600 for non-preferred providers<br>$600 for preferred providers<br>$1,800 for non-preferred providers<br>For family coverage, the deductible applies to the family as a whole.<br>Note: If you (and your enrolled spouse) do not update your contact information, take your Personal Health Assessment (PHA), choose a Primary Care Physician (PCP) and complete health actions during the available time period, your deductible will be higher. |
| Annual Out of Pocket (OOP) Maximum (per calendar year)<br>▪ Employee Only<br>▪ Family<br>Deductible and co-insurance apply to the OOP maximum. | <br>$2,750 for preferred providers<br>$5,500 for non-preferred providers<br>$5,500 for preferred providers<br>$16,500 for non-preferred providers<br>Overall in-network out-of-pocket limit on Essential Health Benefits: $7,150 person / $14,300 family<br>For employees with Family coverage, the "Employee Only coverage" maximum will apply to each covered individual until the "Family coverage" maximum is met. |

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This Plan comparison provides a general overview of Plan benefits. Please refer to your Summary Plan Description for specifics about covered expenses as well as exclusions and limitations.

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## Comparison of Medical/Prescription Drug/Vision Benefits Effective January 1, 2017

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| | Note: If you (and your enrolled spouse) do not update your contact information, take your Personal Health Assessment (PHA), choose a Primary Care Physician (PCP) and complete health actions during the available time period, your out of pocket will be higher. |
| Service Area | Covered services are available from any covered provider. However, if you use a Preferred Provider from the Aetna Choice POS ll network for medical services, your benefits will be greater. All services provided by non-preferred providers are subject to Usual, Customary and Reasonable (UCR) charges. |
| | **Benefit percentages apply after the deductibles have been met (unless otherwise stated).** |
| Hospital | |
| ▪ Room and Board | 80% for preferred providers / 60% for non-preferred providers |
| ▪ Ancillary Services | 80% for preferred providers / 60% for non-preferred providers |
| ▪ Emergency Room | $100 copay at preferred providers and non-preferred facilities, waived if admitted. In addition, subject to deductible and coinsurance. Copay does not apply to OOP maximum, but does apply to the Essential Health Benefits OOP maximum. |
| Ambulance (air/ground) | 80% |
| Surgical Services | 80% for preferred providers / 60% for non-preferred providers |
| Anesthesia | 80% for preferred providers / 60% for non-preferred providers |
| Second Surgical Opinion | 80% for preferred providers / 60% for non-preferred providers |
| Ambulatory Surgical Center | 80% for preferred providers / 60% for non-preferred providers |
| Physician Visits (inpatient) | 80% for preferred providers / 60% for non-preferred providers |
| Physician Visits (outpatient, non-preventive services) | 80% for preferred providers / 60% for non-preferred providers |

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| Diagnostic X-ray and Lab | 80% for preferred providers / 60% for non-preferred providers |
| Dental Treatment | 80% for preferred providers / 60% for Out of Network Providers for treatment for accidental injuries to natural teeth or fractured jaw if treatment is performed within six months from the date of accident.<br>Routine dental treatment is not covered. |
| Nursing Services (inpatient and outpatient) | 80% for preferred providers / 60% for non-preferred providers |
| Blood Transfusion | 80% for preferred providers / 60% for non-preferred providers |
| Medical Supplies and Equipment | 80% for preferred providers / 60% for non-preferred providers |
| Prosthetic Devices | 80% for preferred providers / 60% for non-preferred providers |
| Anesthetic Supplies | 80% for preferred providers / 60% for non-preferred providers |
| Mental and Nervous Disorder<br>▪ Inpatient<br>▪ Outpatient | <br>80% for preferred providers / 60% for non-preferred providers<br>80% for preferred providers / 60% for non-preferred providers |
| Preventive Care:<br>▪ Physical Exam<br>▪ Preventive Screenings, Lab Tests<br>▪ Immunizations and Flu Shots | All preventive services covered in accordance with the Plan's well care schedule:<br>100% for preferred providers (no deductible)<br>60% for non-preferred providers (after deductible) |

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| Chiropractic Care<br><br>(Excess of the $30 per visit applies only to the Essential Health Benefits OOP maximum. Excess of the 20 visits per calendar year does not apply to the OOP maximums.) | 80% for preferred providers / 60% for non-preferred providers<br>▪ Benefit limited to $30 per visit<br>▪ PPO providers provide a discount<br>▪ Maximum of 20 visits per calendar year<br>▪ Chiropractic x-rays limited to one set from one chiropractic visit, per calendar year |
| Podiatry<br><br>(Excess of the $20 per visit and 12 visits per calendar year applies only to the Essential Health Benefits OOP maximum.) | 80% for preferred providers / 60% for non-preferred providers<br>▪ Benefit limited to $20 per visit<br>▪ PPO providers provide a discount<br>▪ Maximum of 12 visits per calendar year |
| Acupuncture<br><br>(Non-covered visits 9 through 12 apply only to the Essential Health Benefits OOP maximum.) | 80% for preferred providers / 60% for non-preferred providers<br>▪ Maximum of 8 visits per calendar year |
| Naturopaths | 80% for preferred providers / 60% for non-preferred providers<br>▪ Maximum of 5 visits per calendar year |
| Alcoholism and Drug Abuse | 80% for preferred providers / 60% for non-preferred providers |

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| Hearing Aid | 80% for preferred providers / 60% for non-preferred providers<br>▪ Maximum of $1,000 in any 3 consecutive calendar years for exam and hearing aid<br>▪ Rental charges covered for up to 30 days |
| Skilled Nursing Facility | 80% for preferred providers / 60% for non-preferred providers |
| Home Health Care | 100% for preferred providers (no deductible) / 60% for non-preferred providers<br>▪ Must be in lieu of confinement in hospital or skilled nursing facility |
| Hospice | 100% for preferred providers (no deductible) / 60% for non-preferred providers |
| Transplant Benefit | 80% for preferred providers / 60% for non-preferred providers<br>▪ Covers only listed procedures |
| Rehabilitation | |
| • Outpatient Services | 80% for preferred providers / 60% for non-preferred providers<br>▪ Maximum of 45 visits per condition per calendar year for physical, occupational, restorative speech, hand and cardiac therapy combined, including services for neurodevelopmentally disabled children age 6 and under |
| • Inpatient Services | 80% for preferred providers / 60% for non-preferred providers<br>▪ Maximum of 30 days per condition per calendar year for physical, occupational, restorative speech, hand and cardiac therapy combined, including services for neurodevelopmentally disabled children age 6 and under |

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| **If you do not identify yourself or dependents as a member of the Sound Health & Wellness Trust to the pharmacist when your prescription is filled, you will be assessed a processing fee in addition to the co-pay. The processing fee for generic is $10; the processing fee for Brand is $20.** | |
| Retail (30 day supply) | Copay per 30-day supply (no deductible): |
| Tier 0: Some highly cost-effective medications<br>▪ Cholesterol Lowering Medications (Simvastatin)<br>▪ Proton Pump Inhibitors (Omeprazole – generic of Prilosec OTC, with physician Rx)<br>▪ Non-sedating Antihistamines (Loratadine - generic of Claritin OTC, with physician RX)<br>▪ Diabetes products (Metformin and lancets) | $0 copay |
| Tier 1: Current Generics, some future generics | $6 copay |
| Tier 2: Most brand drugs, and more costly or less desirable future generics | $22 copay |
| Tier 3: Non-Preferred brand drugs and some undesirable future generics | $35 copay |
| Brand Name Drug with Generic Available: If you fill a prescription for a brand name drug when there is a generic | Generic copay plus the actual difference in cost between the generic and the brand name drug. |

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| Mail Order | Optional (up to 90 day supply) (copays listed are for a 90 day supply) |
| ▪ Tier 0 | $0 copay |
| ▪ Tier 1 | $18 copay |
| ▪ Tier 2 | $66 copay |
| ▪ Tier 3 | $70 copay |
| Exam | 100% at a VSP provider, up to $50 at a non-VSP provider after a $10 copay, once each 12 months from last date of service |
| Vision Hardware | |
| ▪ Lenses | 100% at a VSP provider, from $50 to $100 at a non-VSP provider; once each 12 months from last date of service |
| ▪ Frames | Up to $95 allowance at a VSP provider, up to $70 at a non-VSP provider; once each 24 months from last date of service |
| ▪ Contact lenses | Up to $60 copay for contact lens exam (fitting and evaluation) $130 allowance contact lenses at a VSP provider, up to $105 at a non-VSP provider; once each 12 months from last date of service (contacts are in lieu of lenses) |

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# FURTHER QUESTIONS?

**Sound PPO Plan**
**206-282-4500 or 800-225-7620**
**(Choose member, then option 1)**