

SOUND HEALTH & WELLNESS TRUST
MEDICAL, PRESCRIPTION DRUG AND VISION OPTIONS
FOR
SOUND PLAN
(under 36 months of employment)
2027 OPEN ENROLLMENT

Sound Health & Wellness Trust

Comparison of Medical/Prescription Drug/Vision Benefits Effective January 1, 2027

Sound Plan (under 36 months of employment)

	Sound Kaiser Permanente 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) ▪ Employee Only ▪ Family	\$300 for Kaiser (In-Network) Providers \$600 for Out of Network Providers \$600 for Kaiser (In-Network) Providers \$1,800 for Out of Network Providers For family coverage, the deductible applies to the family as a whole. Note: If you (and your enrolled spouse) do not update your contact information, take your Health Profile, 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) ▪ Employee Only ▪ Family Deductible and co-insurance apply to the OOP maximum.	\$2,750 for Kaiser (In-Network) Providers \$5,500 for Out of Network Providers \$5,500 for Kaiser (In-Network) Providers \$16,500 for Out of Network Providers Overall in-network out-of-pocket limit on Essential Health Benefits: \$10,600 person / \$21,200 family For employees with Family coverage, the "Employee Only coverage" maximum will apply to each covered individual until the "Family coverage" maximum is met. Note: If you (and your enrolled spouse) do not update your contact information, take your Health Profile, choose a Primary Care Physician (PCP) and complete health actions during the available time period, your out of pocket will be higher.

The Trustees do not promise to continue any individual benefit or any level of benefits for any set period of time. They have the right to change, suspend, or discontinue a benefit under the Plan at any time. Changes they make will take effect only after notice to participants.

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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Service Area	When you choose Options In-Network care, you get access to all Kaiser providers. In addition, you have access to a number of contracted community physicians in the area. If you choose Out of Network care, you can see First Choice Health Network or First Health providers at a discounted rate. Or you can see any licensed provider you want for most covered services. Your out of pocket costs will be higher than if you choose care inside the Options network.
	Benefit percentages apply after the deductibles have been met (unless otherwise stated).
Hospital ▪ Room and Board ▪ Ancillary Services ▪ Emergency Room	80% for Kaiser (In-Network) Providers / 60% for Out of Network Providers 80% for Kaiser (In-Network) Providers / 60% for Out of Network Providers \$100 copay at Kaiser designated and non-designated facilities, waived if admitted. In addition, subject to the In-Network deductible and coinsurance. Copay does not apply to OOP maximum, but does apply to the Essential Health Benefits OOP maximum. Worldwide emergency care is covered.
Ambulance (air/ground)	80%
Surgical Services	80% for Kaiser (In-Network) Providers / 60% for Out of Network Providers
Anesthesia	80% for Kaiser (In-Network) Providers / 60% for Out of Network Providers
Second Surgical Opinion	80% for Kaiser (In-Network) Providers / 60% for Out of Network Providers
Ambulatory Surgical Center	80% for Kaiser (In-Network) Providers / 60% for Out of Network Providers
Physician Visits (inpatient)	80% for Kaiser (In-Network) Providers / 60% for Out of Network Providers
Physician Visits (outpatient, non-preventive services)	80% for Kaiser (In-Network) Providers / 60% for Out of Network Providers
Diagnostic X-ray and Lab	80% for Kaiser (In-Network) Providers / 60% for Out of Network Providers

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Dental Treatment	80% for Kaiser (In-Network) 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. Routine dental treatment is not covered.
Nursing Services (inpatient and outpatient)	80% for Kaiser (In-Network) Providers / 60% for Out of Network Providers
Blood Transfusion	80% for Kaiser (In-Network) Providers / 60% for Out of Network Providers
Medical Supplies and Equipment	80% for Kaiser (In-Network) Providers / 60% for Out of Network Providers
Prosthetic Devices	80% for Kaiser (In-Network) Providers / 60% for Out of Network Providers
Anesthetic Supplies	80% for Kaiser (In-Network) Providers / 60% for Out of Network Providers
Mental and Nervous Disorder ▪ Inpatient ▪ Outpatient	80% at Kaiser approved facility / 60% for Out of Network facilities 80% for Kaiser (In-Network) Providers / 60% for Out of Network Providers
Preventive Care: ▪ Physical Exam ▪ Preventive Screenings, Lab Tests ▪ Immunizations and Flu Shots	All preventive services covered in accordance with Kaiser well care schedule: 100% for Kaiser (In-Network) Providers (no deductible) 60% for Out of Network Providers (after deductible)

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Chiropractic Care	80% for Kaiser (In-Network) Providers / 60% for Out of Network Providers Maximum of 10 self-referral visits for manipulative therapy of the spine and extremities per calendar year; additional visits available when approved by Kaiser (In-Network)
Podiatry	80% for Kaiser (In-Network) Providers / 60% for Out of Network Providers Routine foot care not covered, except in the presence of a non-related medical condition affecting the lower limbs
Acupuncture (Non-covered visits 9 through 12 apply only to the Essential Health Benefits OOP maximum.)	80% for Kaiser (In-Network) Providers / 60% for Out of Network Providers Maximum of 8 self-referral visits per calendar year; additional visits available when approved by Kaiser (In-Network)
Naturopaths	80% for Kaiser (In-Network) Providers / 60% for Out of Network Providers Maximum of 5 self-referral visits per diagnosis per calendar year; additional visits available when approved by Kaiser (In-Network)
Alcoholism and Drug Abuse	80% for Kaiser (In-Network) Providers / 60% for Out of Network Providers
Hearing Aid	80% for Kaiser (In-Network) Providers / 60% for Out of Network Providers for exams to determine hearing loss Hearing aids, including hearing aid exams, are covered up to a maximum of \$1,000 per ear, limited to one aid per ear during any 3-year period when authorized by a Kaiser physician (In-Network) or with a physician prescription (Out of Network)
Skilled Nursing Facility	80% for Kaiser (In-Network) Providers / 60% for Out of Network Providers Maximum of 60 days per calendar year
Home Health Care	Covered in full (Out of Network subject to UCR)

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	▪ Must be in lieu of confinement in hospital or skilled nursing facility
Hospice	Covered in full (Out of Network subject to UCR)
Transplant Benefit	80% for Kaiser (In-Network) Providers / 60% for Out of Network Providers
Rehabilitation • Outpatient Services • Inpatient Services	80% for Kaiser (In-Network) Providers / 60% for Out of Network Providers ▪ Maximum of 45 visits per condition per calendar year for physical, occupational and restorative speech therapy combined, including services for neurodevelopmentally disabled children age 6 and under 80% for Kaiser (In-Network) Providers / 60% for Out of Network Providers ▪ Maximum of 30 days per condition per calendar year for physical, occupational and restorative speech therapy combined, including services for neurodevelopmentally disabled children age 6 and under

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Retail (30-day supply) Tier 0: Some highly cost-effective medications ▪ Cholesterol Lowering Medications (Simvastatin) ▪ Proton Pump Inhibitors (Omeprazole – generic of Prilosec OTC, with physician Rx) ▪ Non-sedating Antihistamines (Loratadine - generic of Claritin OTC, with physician RX) ▪ Diabetes products (Metformin and lancets) Tier 1: Current Generics, some future generics Tier 2: Most brand drugs, and costlier or less desirable future generics	Copay per 30-day supply (no deductible): \$0 copay \$6 copay for Generics if on formulary \$22 copay for Brand if on formulary
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 ▪ Tier 0 ▪ Tier 1 ▪ Tier 2	Optional (90-day supply) (copays listed are for a 90-day supply) – no deductible Must use Mail Order Program \$0 copay \$18 copay for Generics if on formulary \$66 copay for Brand if on formulary
Exam Vision Hardware ▪ Lenses ▪ Frames ▪ Contact lenses (Amounts over \$150 will apply to the Essential Health Benefits OOP Maximum.)	80% for Kaiser (In-Network) Providers / 60% for Out of Network Providers (no deductible), once each 12 consecutive months  Up to \$200 (no deductible); once each 12 consecutive months

FURTHER QUESTIONS?

Sound Kaiser Permanente Plan
888-901-4636

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