SOUND HEALTH & WELLNESS TRUST

MEDICAL, PRESCRIPTION DRUG AND VISION OPTIONS

FOR

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

2018 ENROLLMENT

Sound Health & Wellness Trust

Comparison of Medical/Prescription Drug/Vision Benefits Effective January 1, 2018

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) ▪ Employee Only ▪ Family	 $300 for preferred providers $600 for non-preferred providers $600 for preferred providers $1,800 for non-preferred 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 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) ▪ Employee Only ▪ Family Deductible and co-insurance apply to the OOP maximum.	 $2,750 for preferred providers $5,500 for non-preferred providers $5,500 for preferred providers $16,500 for non-preferred providers Overall in-network out-of-pocket limit on Essential Health Benefits: $7,350 person / $14,500 family 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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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. 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 ▪ Inpatient ▪ Outpatient	 80% for preferred providers / 60% for non-preferred providers 80% for preferred providers / 60% for non-preferred providers
Preventive Care: ▪ Physical Exam ▪ Preventive Screenings, Lab Tests ▪ Immunizations and Flu Shots	All preventive services covered in accordance with the Plan's well care schedule: 100% for preferred providers (no deductible) 60% for non-preferred providers (after deductible)

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Chiropractic Care (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 ▪ Benefit limited to $30 per visit ▪ PPO providers provide a discount ▪ Maximum of 20 visits per calendar year ▪ Chiropractic x-rays limited to one set from one chiropractic visit, per calendar year
Podiatry (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 ▪ Benefit limited to $20 per visit ▪ PPO providers provide a discount ▪ Maximum of 12 visits per calendar year
Acupuncture (Non-covered visits 9 through 12 apply only to the Essential Health Benefits OOP maximum.)	80% for preferred providers / 60% for non-preferred providers ▪ Maximum of 8 visits per calendar year
Naturopaths	80% for preferred providers / 60% for non-preferred providers ▪ 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 ▪ Maximum of $1,000 in any 3 consecutive calendar years for exam and hearing aid ▪ 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 ▪ 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 ▪ Covers only listed procedures
Rehabilitation	
• Outpatient Services	80% for preferred providers / 60% for non-preferred providers ▪ 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 ▪ 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 ▪ 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)	$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)