

**SOUND HEALTH & WELLNESS TRUST**

**MEDICAL, PRESCRIPTION DRUG AND VISION OPTIONS**

**FOR**

**SOUND PLAN**

**(under 36 months of employment)**

**2021 ENROLLMENT**

## Sound Health & Wellness Trust

### Comparison of Medical/Prescription Drug/Vision Benefits Effective January 1, 2021

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

	<b>Sound Kaiser Permanente Plan</b>
<b>Prevention @ 100%</b>	All covered in-network preventive care is paid in full - with no deductibles, coinsurance or co-pays.
<b>Tier 0 Prescriptions</b>	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) <ul style="list-style-type: none"> <li>▪ Employee Only</li> <li>▪ Family</li> </ul>	\$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) <ul style="list-style-type: none"> <li>▪ Employee Only</li> <li>▪ Family</li> </ul> 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: \$8,550 person / \$17,100 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.

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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	<p>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.</p> <p>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.</p>
	<b>Benefit percentages apply after the deductibles have been met (unless otherwise stated).</b>
Hospital <ul style="list-style-type: none"> <li>▪ Room and Board</li> <li>▪ Ancillary Services</li> <li>▪ Emergency Room</li> </ul>	<p>80% for Kaiser (In-Network) Providers / 60% for Out of Network Providers</p> <p>80% for Kaiser (In-Network) Providers / 60% for Out of Network Providers</p> <p>\$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.</p>
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 <ul style="list-style-type: none"> <li>▪ Inpatient</li> <li>▪ Outpatient</li> </ul>	<p>80% at Kaiser approved facility / 60% for Out of Network facilities</p> <p>80% for Kaiser (In-Network) Providers / 60% for Out of Network Providers</p>
Preventive Care: <ul style="list-style-type: none"> <li>▪ Physical Exam</li> <li>▪ Preventive Screenings, Lab Tests</li> <li>▪ Immunizations and Flu Shots</li> </ul>	<p>All preventive services covered in accordance with Kaiser well care schedule:</p> <p>100% for Kaiser (In-Network) Providers (no deductible)</p> <p>60% for Out of Network Providers (after deductible )</p>

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Chiropractic Care	80% for Kaiser (In-Network) Providers / 60% for Out of Network Providers <ul style="list-style-type: none"> <li>▪ 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)</li> </ul>
Podiatry	80% for Kaiser (In-Network) Providers / 60% for Out of Network Providers <ul style="list-style-type: none"> <li>▪ Routine foot care not covered, except in the presence of a non-related medical condition affecting the lower limbs</li> </ul>
Acupuncture <small>(Non-covered visits 9 through 12 apply only to the Essential Health Benefits OOP maximum.)</small>	80% for Kaiser (In-Network) Providers / 60% for Out of Network Providers <ul style="list-style-type: none"> <li>▪ Maximum of 8 self-referral visits per calendar year; additional visits available when approved by Kaiser (In-Network)</li> </ul>
Naturopaths	80% for Kaiser (In-Network) Providers / 60% for Out of Network Providers <ul style="list-style-type: none"> <li>▪ Maximum of 5 self-referral visits per diagnosis per calendar year; additional visits available when approved by Kaiser (In-Network)</li> </ul>
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 <ul style="list-style-type: none"> <li>▪ 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)</li> </ul>
Skilled Nursing Facility	80% for Kaiser (In-Network) Providers / 60% for Out of Network Providers <ul style="list-style-type: none"> <li>▪ Maximum of 60 days per calendar year</li> </ul>
Home Health Care	Covered in full (Out of Network subject to UCR)

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	<ul style="list-style-type: none"> <li>▪ Must be in lieu of confinement in hospital or skilled nursing facility</li> </ul>
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 <ul style="list-style-type: none"> <li>• Outpatient Services</li> <li>• Inpatient Services</li> </ul>	80% for Kaiser (In-Network) Providers / 60% for Out of Network Providers <ul style="list-style-type: none"> <li>▪ 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</li> </ul> 80% for Kaiser (In-Network) Providers / 60% for Out of Network Providers <ul style="list-style-type: none"> <li>▪ 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</li> </ul>

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Retail (30 day supply) Tier 0: Some highly cost-effective medications <ul style="list-style-type: none"> <li>▪ Cholesterol Lowering Medications (Simvastatin)</li> <li>▪ Proton Pump Inhibitors (Omeprazole – generic of Prilosec OTC, with physician Rx)</li> <li>▪ Non-sedating Antihistamines (Loratadine - generic of Claritin OTC, with physician RX)</li> <li>▪ Diabetes products (Metformin and lancets)</li> </ul> Tier 1: Current Generics, some future generics Tier 2: Most brand drugs, and more costly or less desirable future generics	Copay per 30-day supply (no deductible):  \$0 copay          \$6 copay for Generics if on Kaiser formulary  \$22 copay for Brand if on Kaiser 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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<p>Mail Order</p> <ul style="list-style-type: none"> <li>▪ Tier 0</li> <li>▪ Tier 1</li> <li>▪ Tier 2</li> </ul>	<p>Optional (90 day supply) (copays listed are for a 90 day supply) – no deductible</p> <p>Must use Kaiser Mail Order Program</p> <p>\$0 copay</p> <p>\$18 copay for Generics if on Kaiser formulary</p> <p>\$66 copay for Brand if on Kaiser formulary</p>
<p>Exam</p> <p>Vision Hardware</p> <ul style="list-style-type: none"> <li>▪ Lenses</li> <li>▪ Frames</li> <li>▪ Contact lenses</li> </ul> <p>(Amounts over \$150 will apply to the Essential Health Benefits OOP Maximum.)</p>	<p>80% for Kaiser (In-Network) Providers / 60% for Out of Network Providers (no deductible), once each 12 consecutive months</p> <p>} Up to \$200 (no deductible); once each 12 consecutive months</p>

**FURTHER QUESTIONS?**

**Sound Kaiser Permanente Plan  
888-901-4636**

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