

SOUND HEALTH & WELLNESS TRUST

**MEDICAL, PRESCRIPTION DRUG AND VISION
OPTIONS**

FOR

SOUND PLAN

Sound Health & Wellness Trust

Comparison of Medical/Prescription Drug/Vision Benefits Effective January 1, 2009

Sound Plan

	Group Health Options (GHO) Plan	Trust Preferred Provider (PPO) Plan (Available only to participants who live outside of the Group Health service area)
Health Reimbursement Account (HRA)	<p>Each year the Plan will fund an HRA account for each employee, based on your level of coverage:</p> <ul style="list-style-type: none"> • Employee Only Coverage: \$500.00 • Family Coverage: \$1,000.00 <p>HRA funds are used to cover eligible medical expenses for such things as your doctor office visits, lab tests, x-rays, emergency room co-pays, in-network co-insurance or other eligible, covered medical expenses covered by the plan in each calendar year.</p> <p>The LiveWell HRA will not be used for prescription, dental or vision benefits. In-network preventive care like wellness visits and mammograms are already covered in full, with no deductibles, coinsurance or co-pays, so your HRA will not be used for these types of services.</p> <p>The funds in your account will be paid out for non-preventive covered medical expenses, before you pay your annual deductible or co-insurance. Once your funds have been used for the year, you are then subject to the annual deductible and coinsurance percentages described below.</p> <p>HRA funding will be prorated for employees who are not eligible during the first quarter and subsequently become eligible.</p>	
Prevention @ 100%	In-network preventive care is now completely covered - with no deductibles, coinsurance or co-pays.	
Tier 0 Prescriptions	A new “Tier 0” has been added to the Trust’s therapeutically based prescription plan. For the highly cost-effective medications under Tier 0, there is \$0 co-pay for participants. Prescriptions under Tier 0 will initially include cholesterol lowering medications (Simvastatin), proton pump inhibitors (Prilosec OTC, with physician prescription), and non-sedating antihistamines (generic Claritin, with physician prescription).	

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Medical Benefits	Group Health Options (GHO) Plan	Trust Preferred Provider (PPO) Plan (Available only to participants who live outside of the Group Health service area)
Service Area	<p>When you choose Options In-Network care, you get access to all Group Health Cooperative 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 Beechstreet 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>	<p>Covered services are available from any covered provider. However, if you use a Preferred Provider from the First Choice network, your benefits will be greater. All services provided by non-preferred providers are subject to Usual, Customary and Reasonable (UCR) charges.</p>
Annual deductible (per calendar year) <ul style="list-style-type: none"> ▪ Individual ▪ Family 	<p>\$250 for Group Health (In-Network) Providers \$500 for Out of Network Providers</p> <p>\$500 for Group Health (In-Network) Providers \$1,500 for Out of Network Providers</p> <ul style="list-style-type: none"> ▪ For Family coverage, the deductible is applied to the family as a whole 	<p>\$250 for preferred providers \$500 for non-preferred providers</p> <p>\$500 for preferred providers \$1,500 for non-preferred providers</p> <ul style="list-style-type: none"> ▪ For Family coverage, the deductible is applied to the family as a whole
Coinsurance	<p>80% for Group Health (In-Network) Providers (after deductible) 60% for Out of Network Providers (after deductible)</p>	<p>80% for preferred providers (after deductible) 60% for non-preferred providers (after deductible)</p>

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Annual Out of Pocket (OOP) Maximum (per calendar year) <ul style="list-style-type: none"> ▪ Individual ▪ Family 	\$2,000 for Group Health (In-Network) Providers \$4,000 for Out of Network Providers \$4,000 for Group Health (In-Network) Providers \$12,000 for Out of Network Providers The following applies to the OOP maximum: <ul style="list-style-type: none"> ▪ Deductible ▪ Coinsurance (20% or 40%) 	\$2,000 for preferred providers \$4,000 for non-preferred providers \$4,000 for preferred providers \$12,000 for non-preferred providers The following applies to the OOP maximum: <ul style="list-style-type: none"> ▪ Deductible ▪ Coinsurance (20% or 40%)
Lifetime Maximum	\$1,500,000 Upon application, full reinstatement if evidence of good health is provided	\$1,500,000 Upon application, full reinstatement if evidence of good health is provided
Hospital <ul style="list-style-type: none"> ▪ Room and Board ▪ Ancillary Services ▪ Emergency Room 	80% for Group Health (In-Network) Providers / 60% for Out of Network Providers (after deductible) 80% for Group Health (In-Network) Providers / 60% for Out of Network Providers (after deductible) \$75 copay at GHO facility / \$125 copay at non-GHO facility, waived if admitted. In addition, subject to deductible and coinsurance. Copay does not apply to OOP maximum. Worldwide emergency care is covered.	80% for preferred providers / 60% for non-preferred providers (after deductible) 80% for preferred providers / 60% for non-preferred providers (after deductible) \$75 copay, waived if admitted. In addition, subject to deductible and coinsurance. Copay does not apply to OOP maximum. Life endangering medical emergency at non-preferred hospital covered as if preferred hospital (subject to UCR).

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Ambulance (Air/Ground)	80% (after deductible)	80% (after deductible)
Surgical Services	80% for Group Health (In-Network) Providers / 60% for Out of Network Providers (after deductible)	80% for preferred providers / 60% for non-preferred providers (after deductible)
Anesthesia	80% for Group Health (In-Network) Providers / 60% for Out of Network Providers (after deductible)	80% for preferred providers / 60% for non-preferred providers (after deductible)
Second Surgical Opinion	80% for Group Health (In-Network) Providers / 60% for Out of Network Providers (after deductible)	80% for preferred providers / 60% for non-preferred providers (after deductible)
Ambulatory Surgical Center	80% for Group Health (In-Network) Providers / 60% for Out of Network Providers (after deductible)	80% for preferred providers / 60% for non-preferred providers (after deductible)
Physician Visits (inpatient)	80% for Group Health (In-Network) Providers / 60% for Out of Network Providers (after deductible)	80% for preferred providers / 60% for non-preferred providers (after deductible)
Physician Visits (outpatient/non-preventive services)	80% for Group Health (In-Network) Providers / 60% for Out of Network Providers (after deductible)	80% for preferred providers / 60% for non-preferred providers (after deductible)
Diagnostic X-ray and Lab	80% for Group Health (In-Network) Providers / 60% for Out of Network Providers (after deductible)	80% for preferred providers / 60% for non-preferred providers (after deductible) <ul style="list-style-type: none"> ▪ Maximum \$60/calendar year for treatment of a musculoskeletal disorder by a licensed chiropractor; excess does not apply to OOP maximum
Dental Treatment	80% for Group Health (In-Network) Providers / 60% for Out of Network Providers (after deductible) 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.	80% for preferred providers / 60% for non-preferred providers (after deductible) 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.

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Nursing Services (inpatient and outpatient)	80% for Group Health (In-Network) Providers / 60% for Out of Network Providers (after deductible)	80% for preferred providers / 60% for non-preferred providers (after deductible)
Blood Transfusion	80% for Group Health (In-Network) Providers / 60% for Out of Network Providers (after deductible)	80% for preferred providers / 60% for non-preferred providers (after deductible)
Medical Supplies and Equipment	80% for Group Health (In-Network) Providers / 60% for Out of Network Providers (after deductible) up to \$2,500 maximum benefit per calendar year	80% for preferred providers / 60% for non-preferred providers (after deductible)
Prosthetic Devices	80% for Group Health (In-Network) Providers / 60% for Out of Network Providers (after deductible) up to \$20,000 maximum benefit per calendar year	80% for preferred providers / 60% for non-preferred providers (after deductible)
Anesthetic Supplies	80% for Group Health (In-Network) Providers / 60% for Out of Network Providers (after deductible)	80% for preferred providers / 60% for non-preferred providers (after deductible)
Mental and Nervous Disorder <ul style="list-style-type: none"> ▪ Inpatient ▪ Outpatient 	80% at GHO Approved Facility / 60% for Out of Network Facility (after deductible) <ul style="list-style-type: none"> ▪ Maximum of 12 days per calendar year 80% for Group Health (In-Network) Providers / 60% for Out of Network Providers (after deductible) <ul style="list-style-type: none"> ▪ Maximum of 20 visits per calendar year ▪ Excess does not apply to OOP maximum 	80% for preferred providers / 60% for non-preferred providers (after deductible) 80% for preferred providers / 60% for non-preferred providers (after deductible)

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Medical Benefits	Group Health Options (GHO) Plan	Trust Preferred Provider (PPO) Plan (Available only to participants who live outside of the Group Health service area)
Preventive Care: Well Adult, Well Child, Well Baby Care <ul style="list-style-type: none"> ▪ Physical Exam ▪ Routine Pap Smear, Mammogram ▪ Preventive Screenings, Lab Tests ▪ Immunizations and Flu Shots 	All preventive services covered in accordance with GHO well care schedules: 100% for Group Health (In-Network) Providers (no deductible) 60% for Out of Network Providers (after deductible)	All preventive services covered in accordance with SHWT well care schedules: 100% for preferred providers (no deductible) 60% for non-preferred providers (after deductible)
Chiropractic Care	80% for Group Health (In-Network) Providers / 60% for Out of Network Providers (after deductible) <ul style="list-style-type: none"> ▪ Maximum of 10 self-referral visits for manipulative therapy of the spine per calendar year; additional visits available when approved by GHO ▪ Excess does not apply to OOP maximum 	80% for preferred providers / 60% for non-preferred providers (after deductible) <ul style="list-style-type: none"> ▪ First Choice PPO providers provide a discount ▪ Benefit limited to \$20 per visit ▪ Maximum of 20 visits per calendar year ▪ Excess does not apply to OOP maximum
Podiatry	80% for Group Health (In-Network) Providers / 60% for Out of Network Providers (after deductible) <ul style="list-style-type: none"> ▪ Routine foot care not covered, except in the presence of a non-related medical condition affecting the lower limbs ▪ Excess does not apply to OOP maximum 	80% for preferred providers / 60% for non-preferred providers (after deductible) <ul style="list-style-type: none"> ▪ First Choice PPO providers provide a discount ▪ Benefit limited to \$20 per visit ▪ Maximum of 12 visits per calendar year ▪ Orthotics limited to \$200 per calendar year ▪ Excess does not apply to OOP maximum

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Acupuncture	80% for Group Health (In-Network) Providers / 60% for Out of Network Providers (after deductible) <ul style="list-style-type: none"> ▪ Maximum of 5 self-referral visits per diagnosis per calendar year; additional visits available when approved by GHO 	80% for preferred providers / 60% for non-preferred providers (after deductible) <ul style="list-style-type: none"> ▪ Maximum 5 visits per calendar year ▪ Excess does not apply to OOP maximum
Naturopaths	80% for Group Health (In-Network) Providers / 60% for Out of Network Providers (after deductible) <ul style="list-style-type: none"> ▪ Maximum of 2 self-referral visits per diagnosis per calendar year; additional visits available when approved by GHO 	80% for preferred providers / 60% for non-preferred providers (after deductible) <ul style="list-style-type: none"> ▪ Maximum of 2 visits per calendar year
Alcoholism and Drug Abuse	80% for Group Health (In-Network) Providers / 60% for Out of Network Providers (after deductible) <ul style="list-style-type: none"> ▪ Maximum of \$5,000 in any 2 consecutive calendar years ▪ Maximum of \$10,000 lifetime ▪ Excess does not apply to OOP maximum 	80% for preferred providers / 60% for non-preferred providers (after deductible) <ul style="list-style-type: none"> ▪ Maximum of \$5,000 in any 2 consecutive calendar years ▪ Maximum of \$10,000 lifetime ▪ Excess does not apply to OOP maximum
Hearing Aid	80% for Group Health (In-Network) Providers / 60% for Out of Network Providers (after deductible) for exam to determine hearing loss. Hearing aids, including hearing aid exams, are covered up to a maximum of \$400 per ear, limited to one aid per ear during any 3-year period when authorized by a GHO physician (In-Network), or by physician prescription Out of Network. <ul style="list-style-type: none"> ▪ Excess does not apply to OOP maximum 	80% for preferred providers / 60% for non-preferred providers (after deductible) <ul style="list-style-type: none"> ▪ Maximum of \$1,000 in any 3 consecutive calendar years for exam and hearing aid ▪ Excess does not apply to OOP maximum ▪ Rental charges covered for up to 30 days

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Medical Benefits	Group Health Options (GHO) Plan	Trust Preferred Provider (PPO) Plan (Available only to participants who live outside of the Group Health service area)
Skilled Nursing Facility	80% for Group Health (In-Network) Providers / 60% for Out of Network Providers (after deductible) <ul style="list-style-type: none"> ▪ Maximum of 60 days per calendar year 	80% for preferred providers / 60% for non-preferred providers (after deductible)
Home Health Care	Covered in full (Out of Network subject to Usual and Customary Charges – UCR) <ul style="list-style-type: none"> ▪ Must be in lieu of confinement in hospital or skilled nursing facility 	Covered in full (Out of Network subject to Usual and Customary Charges – UCR) <ul style="list-style-type: none"> ▪ Must be in lieu of confinement in hospital or skilled nursing facility
Hospice	Covered in full (Out of Network subject to Usual and Customary Charges – UCR)	Covered in full (Out of Network subject to Usual and Customary Charges – UCR)
Transplant Benefit	80% for Group Health (In-Network) Providers / 60% for Out of Network Providers (after deductible)	80% for preferred providers / 60% for non-preferred providers (after deductible) <ul style="list-style-type: none"> ▪ Covers only current listed procedures
Rehabilitation <ul style="list-style-type: none"> ▪ Outpatient Services 	80% for Group Health (In-Network) Providers / 60% for Out of Network Providers (after deductible) <ul style="list-style-type: none"> ▪ 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 preferred providers / 60% for non-preferred providers (after deductible) <ul style="list-style-type: none"> ▪ 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

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Rehabilitation (continued) <ul style="list-style-type: none"> ▪ Inpatient Services 	80% for Group Health (In-Network) Providers / 60% for Out of Network Providers (after deductible) <ul style="list-style-type: none"> ▪ 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 	80% for preferred providers / 60% for non-preferred providers (after deductible) <ul style="list-style-type: none"> ▪ 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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Prescription Drug Benefits	Group Health Options (GHO) Plan	Trust Preferred Provider (PPO) Plan
<p>Retail (30 day supply)</p> <p>Tier 0: Some highly cost-effective medications</p> <ul style="list-style-type: none"> ▪ Cholesterol Lowering Medications (Simvastatin) ▪ Proton Pump Inhibitors (Prilosec OTC, with physician Rx) ▪ Non-sedating Antihistamines (Claritin OTC, with physician RX) <p>Tier 1: Current Generics, some future generics</p> <p>Tier 2: Most brand drugs, and more costly or less desirable future generics</p> <p>Tier 3: Non-Preferred brand drugs and some undesirable future generics</p>	<p>Co-pay per 30-day supply:</p> <p>\$0 copay</p> <p>\$10 copay for Generics if on GHO formulary</p> <p>\$20 copay for Brand if on GHO formulary</p> <p>Not covered if not on GHO formulary</p>	<p>Purchased at a “Trust Network” Pharmacy – copay per 30-day supply:</p> <p>\$0 copay</p> <p>\$10 copay</p> <p>\$20 copay</p> <p>\$30 copay</p>
<p>Brand Name Drug with Generic Available: If you fill a prescription for a brand name drug when there is a generic</p>	<p>Not applicable</p>	<p>Generic copay plus the actual difference in cost between the generic and the brand name drug</p> <p>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.</p>

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Prescription Drug Benefits	Group Health Options (GHO) Plan	Trust Preferred Provider (PPO) Plan
Maintenance at Retail <ul style="list-style-type: none"> ▪ Tier 3 maintenance drugs 	Not available	Purchased at certain “Trust Network” pharmacies: \$60 for a 90 day supply
<ul style="list-style-type: none"> ▪ Mail Order ▪ Tier 0 ▪ Tier 1 ▪ Tier 2 ▪ Tier 3 ▪ Brand Name Drug with Generic Available 	Optional (90 day supply) (copays listed are for a 90 day supply) <ul style="list-style-type: none"> ▪ Must use Group Health Mail Order program ▪ Prescription must be on GHO formulary \$0 copay \$30 copay for Generics if on GHO formulary \$60 copay for Brand if on GHO formulary Not covered if not on GHO formulary Not applicable	Optional (up to 90 day supply) (copays listed are for a 90 day supply) \$0 copay \$30 copay \$60 copay \$90 copay Generic copay plus the actual difference in cost between the generic and the brand name drug

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Vision Benefits	Group Health Options (GHO) Plan	Vision Service Plan (VSP)
<p>Exam</p> <p>Vision Hardware</p> <ul style="list-style-type: none"> ▪ Lenses ▪ Frames ▪ Contact lenses 	<p>80% for Group Health (In-Network) Providers / 60% for Out of Network Providers not subject to deductible or coinsurance; once each 12 consecutive months</p> <p>Up to \$150; once each 12 consecutive months</p> <p>Subject to a 12 month benefit wait period. Benefit does not start for subscriber or dependents until the subscriber has been employed by the group for 12 months.</p>	<p>100% at a VSP provider, up to \$35 at a non-VSP provider, after a \$10 copay; once each 12 consecutive months</p> <p>100% at a VSP provider, from \$30 to \$90 at a non-VSP provider; once each 12 consecutive months</p> <p>100% at a VSP provider up to \$30 at a non-VSP provider; once each 24 consecutive months</p> <p>Up to \$130 at a VSP provider, up to \$55 at a non-VSP provider; once each 12 consecutive months</p>

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Time Loss	<p>This benefit is available only to eligible employees who have worked for a participating employer for 12 months and met other eligibility rules.</p> <p>If you are totally disabled because of your injury or sickness, you may be eligible for weekly disability benefits. The benefit amount is based on your hours of employment reported to the Trust for your eligibility determination month. Your eligibility determination month is two months before you become disabled and stop active work. (For example, if you're disabled in July, the weekly benefit is based on employment hours in May.)</p> <p>Weekly Disability Payment</p> <table border="0"> <thead> <tr> <th>Hours Employed in Eligibility Determination Month</th> <th>Maximum Weekly Benefit</th> </tr> </thead> <tbody> <tr> <td>Less than 80</td> <td>\$ 0</td> </tr> <tr> <td>80 but less than 120</td> <td>135</td> </tr> <tr> <td>120 but less than 150</td> <td>180</td> </tr> <tr> <td>150 or more</td> <td>225</td> </tr> </tbody> </table>	Hours Employed in Eligibility Determination Month	Maximum Weekly Benefit	Less than 80	\$ 0	80 but less than 120	135	120 but less than 150	180	150 or more	225	<p>This benefit is available only to eligible employees who have worked for a participating employer for 12 months and met other eligibility rules.</p> <p>If you are totally disabled because of your injury or sickness, you may be eligible for weekly disability benefits. The benefit amount is based on your hours of employment reported to the Trust for your eligibility determination month. Your eligibility determination month is two months before you become disabled and stop active work. (For example, if you're disabled in July, the weekly benefit is based on employment hours in May.)</p> <p>Weekly Disability Payment</p> <table border="0"> <thead> <tr> <th>Hours Employed in Eligibility Determination Month</th> <th>Maximum Weekly Benefit</th> </tr> </thead> <tbody> <tr> <td>Less than 80</td> <td>\$ 0</td> </tr> <tr> <td>80 but less than 120</td> <td>135</td> </tr> <tr> <td>120 but less than 150</td> <td>180</td> </tr> <tr> <td>150 or more</td> <td>225</td> </tr> </tbody> </table>	Hours Employed in Eligibility Determination Month	Maximum Weekly Benefit	Less than 80	\$ 0	80 but less than 120	135	120 but less than 150	180	150 or more	225
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Life Insurance	<p>This benefit is available only to eligible employees who have worked for a participating employer for 12 months and met other eligibility rules.</p> <p>Employee – Your life insurance benefit is \$15,000. The amount will be paid to your beneficiary in the event of your death from any cause.</p> <p>Dependent – Your spouse’s or same sex domestic partner’s life insurance benefit is \$1,000. The amount will be paid to you in the event of your spouse’s or partner’s death from any cause.</p>	<p>This benefit is available only to eligible employees who have worked for a participating employer for 12 months and met other eligibility rules.</p> <p>Employee – Your life insurance benefit is \$15,000. The amount will be paid to your beneficiary in the event of your death from any cause.</p> <p>Dependent – Your spouse’s or same sex domestic partner’s life insurance benefit is \$1,000. The amount will be paid to you in the event of your spouse’s or partner’s death from any cause.</p>
Accidental Death & Dismemberment	<p>This benefit is available only to eligible employees who have worked for a participating employer for 12 months and met other eligibility rules.</p> <p>This benefit is payable to your beneficiary in the event of your death, or to you in the event of your loss, if your death or loss is caused by an accidental injury while you’re covered under the Plan. To be covered, your death or loss must occur within one year of the injury.</p>	<p>This benefit is available only to eligible employees who have worked for a participating employer for 12 months and met other eligibility rules.</p> <p>This benefit is payable to your beneficiary in the event of your death, or to you in the event of your loss, if your death or loss is caused by an accidental injury while you’re covered under the Plan. To be covered, your death or loss must occur within one year of the injury.</p>
Nurse Helpline	<p>Group Health Consulting Nurse helpline—You can call (800) 297-6877 24 hours a day, 7 days a week with your healthcare questions, and knowledgeable registered nurses will confidentially help you make informed decisions.</p>	<p>LiveWell Nurse Line Plus—You can call (877) 362-9969 24 hours a day, 7 days a week with your healthcare questions—including how to navigate the healthcare system—and knowledgeable registered nurses will confidentially help you make informed decisions.</p>

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Personal Health Assessment	Each year you will have the opportunity to take a personal health assessment and receive an incentive. You will receive a snapshot of your current health status along with information and recommendations for how to get and stay healthy. It will be integrated into your electronic medical record if you get your care at Group Health medical centers. Your responses to these health questions are completely confidential, protected by federal law, and cannot be shared with anyone (including the Trust or your employer) without your permission.	Each year you will have the opportunity to take a personal health assessment and receive an incentive. You will receive a snapshot of your current health status along with information and recommendations for how to get and stay healthy. Your responses to these health questions are completely confidential, protected by federal law, and cannot be shared with anyone (including the Trust or your employer) without your permission.
Coaching	If, through your personal health assessment, you are identified as possibly needing help in a specific area, you will be offered the chance to take advantage of personalized health coaching at no additional cost. Personalized health coaching is a phone-based health education program designed to help you make positive changes in your eating habits, physical activity, tobacco use, or how you cope with stress as well as help you manage chronic conditions such as diabetes and heart disease.	If, through your personal health assessment, you are identified as possibly needing help in a specific area, you will be offered the chance to take advantage of personalized health coaching at no additional cost. Personalized health coaching is a phone-based health education program designed to help you make positive changes in your eating habits, physical activity, tobacco use, or how you cope with stress as well as help you manage chronic conditions such as diabetes and heart disease.
LiveWell Online	Through MyGroupHealth for Members, accessed at www.ghc.org , participants can find health information, tools and services that make healthcare accessible and convenient, 24/7.	On the LiveWell health and wellness site, accessed at www.soundhealthwellness.com , you can find health information, tools and resources to help you create positive lifestyle changes.

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FURTHER QUESTIONS?

PPO Medical Option (out of area)
206-282-4500 or 800-225-7620
(choose member, then Option 2)

Group Health Options
www.ghc.org
888-901-4636

First Choice Preferred Provider Network
www.fchn.com