

SOUND HEALTH & WELLNESS TRUST

MEDICAL, PRESCRIPTION DRUG AND VISION OPTIONS

FOR

SOUND PLAN

(over 36 months of employment)

2012 OPEN ENROLLMENT

Sound Health & Wellness Trust

Comparison of Medical/Prescription Drug/Vision Benefits Effective January 1, 2012

Sound Plan (over 36 months of employment)

	Sound (PPO) Plan	Group Health Options (GHO) 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 (Prilosec OTC, with physician prescription), non-sedating antihistamines (generic 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"> ▪ 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 or same sex domestic partner) do not update your contact information, take your Personal Health Assessment (PHA) and choose a Primary Care Physician (PCP) during the available time period, your deductible will be higher.	\$300 for Group Health (In-Network) Providers \$600 for Out of Network Providers \$600 for Group Health (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 or same sex domestic partner) do not update your contact information, take your Personal Health Assessment (PHA) and choose a Primary Care Physician (PCP) 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"> ▪ 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 For employees with Family coverage, the "Employee Only coverage" maximum will apply to each covered individual until the "Family coverage" maximum is met.	\$2,750 for Group Health (In-Network) Providers \$5,500 for Out of Network Providers \$5,500 for Group Health (In-Network) Providers \$16,500 for Out of Network Providers For employees with Family coverage, the "Employee Only coverage" maximum will apply to each covered individual until the "Family coverage" maximum is met.

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.

Sound Health & Wellness Trust

Comparison of Medical/Prescription Drug/Vision Benefits Effective January 1, 2012

Sound Plan (over 36 months of employment)

	Sound (PPO) Plan	Group Health Options (GHO) Plan
	Note: If you (and your enrolled spouse or same sex domestic partner) do not update your contact information, take your Personal Health Assessment (PHA) and choose a Primary Care Physician (PCP) during the available time period, your deductible will be higher.	Note: If you (and your enrolled spouse or same sex domestic partner) do not update your contact information, take your Personal Health Assessment (PHA) and choose a Primary Care Physician (PCP) during the available time period, your deductible will be higher.
Annual Maximum	\$1,500,000	\$1,500,000
Service Area	Covered services are available from any covered provider. However, if you use a Preferred Provider from the First Choice network for medical services or Optum Behavioral Health network for mental health and substance abuse services, your benefits will be greater. All services provided by non-preferred providers are subject to Usual, Customary and Reasonable (UCR) charges.	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. 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.
Benefit percentages apply after deductibles have been met (unless otherwise stated).		
Hospital		
<ul style="list-style-type: none"> ▪ Room and Board ▪ Ancillary Services ▪ Emergency Room 	<p>80% for preferred providers / 60% for non-preferred providers</p> <p>80% for preferred providers / 60% for non-preferred providers</p> <p>\$100 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).</p>	<p>80% for Group Health (In-Network) Providers / 60% for Out of Network Providers</p> <p>80% for Group Health (In-Network) Providers / 60% for Out of Network Providers</p> <p>\$100 copay at Group Health designated and non-designated facilities, waived if admitted. In addition, subject to In-Network deductible and coinsurance. Copay does not apply to OOP max. Worldwide emergency care is covered.</p>

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.

Sound Health & Wellness Trust

Comparison of Medical/Prescription Drug/Vision Benefits Effective January 1, 2012

Sound Plan (over 36 months of employment)

	Sound (PPO) Plan	Group Health Options (GHO) Plan
Ambulance (air/ground)	80%	80%
Surgical Services	80% for preferred providers / 60% for non-preferred providers	80% for Group Health (In-Network) Providers / 60% for Out of Network Providers
Anesthesia	80% for preferred providers / 60% for non-preferred providers	80% for Group Health (In-Network) Providers / 60% for Out of Network Providers
Second Surgical Opinion	80% for preferred providers / 60% for non-preferred providers	80% for Group Health (In-Network) Providers / 60% for Out of Network Providers
Ambulatory Surgical Center	80% for preferred providers / 60% for non-preferred providers	80% for Group Health (In-Network) Providers / 60% for Out of Network Providers
Physician Visits (inpatient)	80% for preferred providers / 60% for non-preferred providers	80% for Group Health (In-Network) Providers / 60% for Out of Network Providers
Physician Visits (outpatient, non-preventive services)	80% for preferred providers / 60% for non-preferred providers	80% for Group Health (In-Network) Providers / 60% for Out of Network Providers
Diagnostic X-ray and Lab	80% for preferred providers / 60% for non-preferred providers <ul style="list-style-type: none"> ▪ \$60 per calendar year for diagnostic x-ray and laboratory expenses in connection with chiropractic treatment. 	80% for Group Health (In-Network) Providers / 60% for Out of Network Providers
Dental Treatment	80% for preferred providers / 60% for non-preferred 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.	80% for Group Health (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 preferred providers / 60% for non-preferred providers	80% for Group Health (In-Network) Providers / 60% for Out of Network Providers

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.

Sound Health & Wellness Trust

Comparison of Medical/Prescription Drug/Vision Benefits Effective January 1, 2012

Sound Plan (over 36 months of employment)

	Sound (PPO) Plan	Group Health Options (GHO) Plan
Blood Transfusion	80% for preferred providers / 60% for non-preferred providers	80% for Group Health (In-Network) Providers / 60% for Out of Network Providers
Medical Supplies and Equipment	80% for preferred providers / 60% for non-preferred providers	80% for Group Health (In-Network) Providers / 60% for Out of Network Providers
Prosthetic Devices	80% for preferred providers / 60% for non-preferred providers	80% for Group Health (In-Network) Providers / 60% for Out of Network Providers
Anesthetic Supplies	80% for preferred providers / 60% for non-preferred providers	80% for Group Health (In-Network) Providers / 60% for Out of Network Providers
Mental and Nervous Disorder <ul style="list-style-type: none"> ▪ Inpatient ▪ Outpatient 	<p>80% for Optum providers / 60% for non-Optum providers</p> <p>80% for Optum providers / 60% for non-Optum providers</p>	<p>80% at GHO approved facility / 60% for Out of Network facilities</p> <ul style="list-style-type: none"> ▪ Maximum of 12 days per calendar year ▪ Excess does not apply to OOP maximum <p>80% for Group Health (In-Network) Providers / 60% for Out of Network Providers</p> <ul style="list-style-type: none"> ▪ Maximum of 20 visits per calendar year ▪ Excess does not apply to OOP maximum
Preventive Care: <ul style="list-style-type: none"> ▪ Physical Exam ▪ Preventive Screenings, Lab Tests ▪ Immunizations and Flu Shots 	<p>All preventive services covered in accordance with the Plan's well care schedule:</p> <p>100% for preferred providers (no deductible)</p> <p>60% for non-preferred providers (after deductible)</p>	<p>All preventive services covered in accordance with GHO well care schedule:</p> <p>100% for Group Health (In-Network) Providers (no deductible)</p> <p>60% for Out of Network Providers (after deductible)</p>

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.

Sound Health & Wellness Trust

Comparison of Medical/Prescription Drug/Vision Benefits Effective January 1, 2012

Sound Plan (over 36 months of employment)

	Sound (PPO) Plan	Group Health Options (GHO) Plan
Chiropractic Care	80% for preferred providers / 60% for non-preferred providers <ul style="list-style-type: none"> ▪ Benefit limited to \$30 per visit ▪ First Choice PPO providers provide a discount ▪ Maximum of 20 visits per calendar year ▪ Excess does not apply to OOP maximum 	80% for Group Health (In-Network) Providers / 60% for Out of Network Providers <ul style="list-style-type: none"> ▪ Maximum of 10 self-referral visits for manipulative therapy of the spine and extremities per calendar year; additional visits available when approved by GHO (In-Network) ▪ Excess does not apply to OOP maximum
Podiatry	80% for preferred providers / 60% for non-preferred providers <ul style="list-style-type: none"> ▪ Benefit limited to \$20 per visit ▪ First Choice PPO providers provide a discount ▪ Maximum of 12 visits per calendar year ▪ Orthotics limited to \$200 per calendar year ▪ Excess does not apply to OOP maximum 	80% for Group Health (In-Network) Providers / 60% for Non-Network and Out of Network Providers <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
Acupuncture	80% for preferred providers / 60% for non-preferred providers <ul style="list-style-type: none"> ▪ Maximum of 8 visits per calendar year ▪ Excess does not apply to OOP maximum 	80% for Group Health (In-Network) Providers / 60% for Out of Network Providers <ul style="list-style-type: none"> ▪ Maximum of 8 self-referral visits per diagnosis per calendar year; additional visits available when approved by GHO (In-Network) ▪ Excess not apply to OOP maximum
Naturopaths	80% for preferred providers / 60% for non-preferred providers <ul style="list-style-type: none"> ▪ Maximum of 5 visits per calendar year ▪ Excess does not apply to OOP maximum 	80% for Group Health (In-Network) Providers / 60% for Out of Network Providers <ul style="list-style-type: none"> ▪ Maximum of 5 self-referral visits per calendar year; additional visits available when approved by GHO (In-Network) ▪ Excess does not apply to OOP maximum

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.

Sound Health & Wellness Trust

Comparison of Medical/Prescription Drug/Vision Benefits Effective January 1, 2012

Sound Plan (over 36 months of employment)

	Sound (PPO) Plan	Group Health Options (GHO) Plan
Alcoholism and Drug Abuse	80% for preferred providers / 60% for non-preferred providers <ul style="list-style-type: none"> ▪ Up to 3 inpatient days for supervised inpatient detoxification (Detox) per Acute Occurrence. ▪ Acute Occurrence of substance abuse will consist of up to 12 days of inpatient therapy or its' outpatient equivalent or combination thereof. 	80% for Group Health (In-Network) Providers / 60% for Out of Network Providers
Hearing Aid	80% for preferred providers / 60% for non-preferred providers <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 	80% for Group Health (In-Network) Providers / 60% for Out of Network Providers for exams to determine hearing loss <ul style="list-style-type: none"> ▪ 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 with a physician prescription (Out of Network) ▪ Excess does not apply to OOP maximum
Skilled Nursing Facility	80% for preferred providers / 60% for non-preferred providers	80% for Group Health (In-Network) Providers / 60% for Out of Network Providers <ul style="list-style-type: none"> ▪ Maximum of 60 days per calendar year
Home Health Care	Covered in full (Out of Network Subject to 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 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 UCR)	Covered in full (Out of Network subject to UCR)
Transplant Benefit	80% for preferred providers / 60% for non-preferred providers <ul style="list-style-type: none"> ▪ Covers only listed procedures 	80% for Group Health (In-Network) Providers / 60% for Out of Network Providers

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.

Sound Health & Wellness Trust

Comparison of Medical/Prescription Drug/Vision Benefits Effective January 1, 2012

Sound Plan (over 36 months of employment)

	Sound (PPO) Plan	Group Health Options (GHO) Plan
Rehabilitation <ul style="list-style-type: none"> ▪ Outpatient Services ▪ Inpatient Services 	80% for preferred providers / 60% for non-preferred providers <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 ▪ Excess does not apply to OOP maximum 80% for preferred providers / 60% for non-preferred providers <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 ▪ Excess does not apply to OOP maximum 	80% for Group Health (In-Network) Providers / 60% for Out of Network Providers <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 ▪ Excess does not apply to OOP maximum 80% for Group Health (In-Network) Providers / 60% for Out of Network Providers <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 ▪ Excess does not apply to OOP maximum

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.

Sound Health & Wellness Trust

Comparison of Medical/Prescription Drug/Vision Benefits Effective January 1, 2012

Sound Plan (over 36 months of employment)

	Sound (PPO) Plan	Group Health Options (GHO) Plan
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)	Purchased at a "Trust Network" Pharmacy – copay per 30-day supply:	Copay per 30-day supply (no deductible):
Tier 0: Some highly cost-effective medications <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) ▪ Diabetes products (Metformin and lancets) 	\$0 copay	\$0 copay
Tier 1: Current Generics, some future generics	\$6 copay	\$6 copay for Generics if on GHO formulary
Tier 2: Most brand drugs, and more costly or less desirable future generics	\$22 copay	\$22 copay for Brand if on GHO formulary
Tier 3: Non-Preferred brand drugs and some undesirable future generics	\$35 copay	Not applicable
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	Generic copay plus the actual difference in cost between the generic and the brand name drug.

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.

Sound Health & Wellness Trust

Comparison of Medical/Prescription Drug/Vision Benefits Effective January 1, 2012

Sound Plan (over 36 months of employment)

	Sound (PPO) Plan	Group Health Options (GHO) Plan
Maintenance "Mail" at Retail <ul style="list-style-type: none"> ▪ Tier 3 maintenance drugs 	Purchased at certain "Trust Network" pharmacies: \$66 for a 90 day supply	Not available
Mail Order <ul style="list-style-type: none"> ▪ Tier 0 ▪ Tier 1 ▪ Tier 2 ▪ Tier 3 Brand Name Drug with Generic Available	Optional (up to 90 day supply) (copays listed are for a 90 day supply) \$0 copay \$18 copay \$66 copay \$70 copay Generic copay plus the actual difference in cost between the generic and the brand name drug	Optional (90 day supply) (copays listed are for a 90 day supply) – no deductible <ul style="list-style-type: none"> ▪ Must use Group Health Mail Order Program \$0 copay \$18 copay for Generics if on GHO formulary \$66 copay for Brand if on GHO formulary Not applicable Generic copay plus the actual difference in cost between the generic and the brand name drug

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.

Sound Health & Wellness Trust

Comparison of Medical/Prescription Drug/Vision Benefits Effective January 1, 2012

Sound Plan (over 36 months of employment)

	Sound (PPO) Plan	Group Health Options (GHO) Plan
Exam	100% at a VSP provider, up to \$35 at a non-VSP provider after a \$10 copay, once each 12 months from last date of service	80% for Group Health (In-Network) Providers / 60% for Out of Network Providers (no deductible), once each 12 consecutive months } Up to \$150 (no deductible); once each 12 consecutive months
Vision Hardware	100% at a VSP provider, from \$30 to \$90 at a non-VSP provider; once each 12 months from last date of service	
▪ Lenses	Up to \$95 allowance at a VSP provider, up to \$30 at a non-VSP provider; once each 24 months from last date of service	
▪ Frames	Up to \$130 allowance at a VSP provider, up to \$55 at a non-VSP provider; once each 12 months from last date of service (contacts are in lieu of lenses and a frame)	
▪ Contact lenses		

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.

FURTHER QUESTIONS?

**Sound PPO Medical Option
206-282-4500 or 800-225-7620
(choose member, then Option 1)**

**First Choice Preferred Provider Network
www.fchn.com
800-843-5127**

**Optum Behavioral Health Network
866-763-0466**

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