

SOUND HEALTH & WELLNESS TRUST

MEDICAL, PRESCRIPTION DRUG AND VISION OPTIONS

FOR

SOUND PLAN

(under 36 months of employment)

2012 ENROLLMENT

Sound Health & Wellness Trust

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

Sound Plan (under 36 months of employment)

	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 	<p>\$300 for Group Health (In-Network) Providers \$600 for Out of Network Providers</p> <p>\$600 for Group Health (In-Network) Providers \$1,800 for Out of Network Providers</p> <p>For family coverage, the deductible applies to the family as a whole.</p> <p>Note: If you (and your enrolled spouse or same sex domestic partner) do not update your contact information, take your Health Profile and choose a Primary Care Physician (PCP) during the available time period, your deductible will be higher.</p>
Annual Out of Pocket (OOP) Maximum (per calendar year) <ul style="list-style-type: none"> ▪ Employee Only ▪ Family <p>Deductible and co-insurance apply to the OOP maximum.</p>	<p>\$2,750 for Group Health (In-Network) Providers \$5,500 for Out of Network Providers</p> <p>\$5,500 for Group Health (In-Network) Providers \$16,500 for Out of Network Providers</p> <p>For employees with Family coverage, the "Employee Only coverage" maximum will apply to each covered individual until the "Family coverage" maximum is met.</p> <p>Note: If you (and your enrolled spouse or same sex domestic partner) do not update your contact information, take your Health Profile and choose a Primary Care Physician (PCP) during the available time period, your deductible will be higher.</p>
Annual Maximum	\$1,500,000

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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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Group Health Options (GHO) Plan	
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>
Benefit percentages apply after the deductibles have been met (unless otherwise stated).	
Hospital <ul style="list-style-type: none"> ▪ Room and Board ▪ Ancillary Services ▪ Emergency Room 	<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 the In-Network deductible and coinsurance. Copay does not apply to OOP max. Worldwide emergency care is covered.</p>
Ambulance (air/ground)	80%
Surgical Services	80% for Group Health (In-Network) Providers / 60% for Out of Network Providers
Anesthesia	80% for Group Health (In-Network) Providers / 60% for Out of Network Providers
Second Surgical Opinion	80% for Group Health (In-Network) Providers / 60% for Out of Network Providers
Ambulatory Surgical Center	80% for Group Health (In-Network) Providers / 60% for Out of Network Providers
Physician Visits (inpatient)	80% for Group Health (In-Network) Providers / 60% for Out of Network Providers
Physician Visits (outpatient, non-preventive services)	80% for Group Health (In-Network) Providers / 60% for Out of Network Providers
Diagnostic X-ray and Lab	80% for Group Health (In-Network) Providers / 60% for Out of Network Providers

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	Group Health Options (GHO) Plan
Dental Treatment	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 Group Health (In-Network) Providers / 60% for Out of Network Providers
Blood Transfusion	80% for Group Health (In-Network) Providers / 60% for Out of Network Providers
Medical Supplies and Equipment	80% for Group Health (In-Network) Providers / 60% for Out of Network Providers
Prosthetic Devices	80% for Group Health (In-Network) Providers / 60% for Out of Network Providers
Anesthetic Supplies	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% at GHO approved facility / 60% for Out of Network facilities</p> <ul style="list-style-type: none"> ▪ Maximum of 12 days per calendar year <p>Excess does not apply to OOP maximum</p> <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 <p>Excess does not apply to OOP maximum</p>
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 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>

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	Group Health Options (GHO) Plan
Chiropractic Care	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 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 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 Group Health (In-Network) Providers / 60% for Out of Network Providers <ul style="list-style-type: none"> ▪ Maximum of 5 self-referral visits per diagnosis per calendar year; additional visits available when approved by GHO (In-Network) ▪ Excess does not apply to OOP maximum
Alcoholism and Drug Abuse	80% for Group Health (In-Network) Providers / 60% for Out of Network Providers

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Hearing Aid	<p>80% for Group Health (In-Network) Providers / 60% for Out of Network Providers for exams to determine hearing loss</p> <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	<p>80% for Group Health (In-Network) Providers / 60% for Out of Network Providers Maximum of 60 days per calendar year</p>
Home Health Care	<p>Covered in full (Out of Network subject to UCR)</p> <ul style="list-style-type: none"> ▪ Must be in lieu of confinement in hospital or skilled nursing facility
Hospice	<p>Covered in full (Out of Network subject to UCR)</p>
Transplant Benefit	<ul style="list-style-type: none"> ▪ 80% for Group Health (In-Network) Providers / 60% for Out of Network Providers
Rehabilitation <ul style="list-style-type: none"> • Outpatient Services • Inpatient Services 	<p>80% for Group Health (In-Network) Providers / 60% for Out of Network Providers</p> <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 <p>80% for Group Health (In-Network) Providers / 60% for Out of Network Providers</p> <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

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<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) ▪ Diabetes products (Metformin and lancets) <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>Copay per 30-day supply (no deductible):</p> <p>\$0 copay</p> <p>\$6 copay for Generics if on GHO formulary</p> <p>\$22 copay for Brand if on GHO formulary</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>Generic copay plus the actual difference in cost between the generic and the brand name drug.</p>
<p>Mail Order</p> <ul style="list-style-type: none"> ▪ Tier 0 ▪ Tier 1 ▪ Tier 2 	<p>Optional (90 day supply) (copays listed are for a 90 day supply) – no deductible</p> <p>Must use Group Health Mail Order Program</p> <p>\$0 copay</p> <p>\$18 copay for Generics if on GHO formulary</p> <p>\$66 copay for Brand if on GHO formulary</p>


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Group Health Options (GHO) Plan	
Exam	80% for Group Health (In-Network) Providers / 60% for Out of Network Providers (no deductible), once each 12 consecutive months
Vision Hardware <ul style="list-style-type: none"> ▪ Lenses ▪ Frames ▪ Contact lenses 	 <p>Up to \$150 (no deductible); once each 12 consecutive months</p>

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FURTHER QUESTIONS?

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