

SOUND HEALTH & WELLNESS TRUST

**MEDICAL, PRESCRIPTION DRUG AND VISION
OPTIONS**

FOR

SOUNDPLUS PLAN

Sound Health & Wellness Trust

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

SoundPlus PPO Plan

| | SoundPlus (PPO) Plan | Group Health Options (GHO) Plan |
|--------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------|
| LiveWell Health Reimbursement Arrangement (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. For SoundPlus participants, out-of-network benefits are also covered.</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, <i>before you pay your annual deductible or co-insurance</i>. 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). | |

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 the Plan Booklet 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, 2009

SoundPlus PPO Plan

| Medical Benefits | SoundPlus (PPO) Plan | Group Health Options (GHO) Plan |
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| Service Area | 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>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> |
| Annual deductible (per calendar year) <ul style="list-style-type: none"> ▪ Individual ▪ Family | \$150 for preferred providers \$300 for non-preferred providers \$300 for preferred providers \$600 for non-preferred providers <ul style="list-style-type: none"> ▪ For Family coverage, the deductible is applied to the family as a whole | \$150 for Group Health (In-Network) Providers \$300 for Out of Network Providers \$300 for Group Health (In-Network) Providers \$600 for Out of Network Providers <ul style="list-style-type: none"> ▪ For Family coverage, the deductible is applied to the family as a whole |
| Coinsurance | 85% for preferred providers 60% for non-preferred providers | 85% for Group Health (In-Network) Providers 60% for Out of Network Providers |
| Annual Out of Pocket (OOP) Maximum (per calendar year) <ul style="list-style-type: none"> ▪ Individual | \$1,000 for preferred providers \$2,000 for non-preferred providers | \$1,000 for Group Health (In-Network) Providers \$2,000 for Out of Network Providers |

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| Annual Out of Pocket (OOP) Maximum (per calendar year) (continued) <ul style="list-style-type: none"> ▪ Family | \$2,000 for preferred providers \$4,000 for non-preferred providers The following applies to the OOP maximum: <ul style="list-style-type: none"> ▪ Deductible ▪ Coinsurance (15% or 40%) | \$2,000 for Group Health (In-Network) Providers \$4,000 for Out of Network Providers The following applies to the OOP maximum: <ul style="list-style-type: none"> ▪ Deductible ▪ Coinsurance (15% 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 | 85% for preferred providers / 60% for non-preferred providers (after deductible) 85% for preferred providers / 60% for non-preferred providers (after deductible) \$50 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. | 85% for Group Health (In-Network) Providers / 60% for Out of Network Providers (after deductible) 85% for Group Health (In-Network) Providers / 60% for Out of Network Providers (after deductible) \$50 copay at GHO designated facility / \$100 copay at non-GHO designated facility, waived if admitted. In addition, subject to deductible and coinsurance. Copay does not apply to OOP max. Worldwide emergency care is covered. |
| Ambulance (air/ground) | 85% (after deductible) | 85% (after deductible) |
| Surgical Services | 85% for preferred providers / 60% for non-preferred providers (after deductible) | 85% for Group Health (In-Network) Providers / 60% for Out of Network Providers (after deductible) |

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| Anesthesia | 85% for preferred providers / 60% for non-preferred providers (after deductible) | 85% for Group Health (In-Network) Providers / 60% for Out of Network Providers (after deductible) |
| Second Surgical Opinion | 85% for preferred providers / 60% for non-preferred providers (after deductible) | 85% for Group Health (In-Network) Providers / 60% for Out of Network Providers (after deductible) |
| Ambulatory Surgical Center | 85% for preferred providers / 60% for non-preferred providers (after deductible) | 85% for Group Health (In-Network) Providers / 60% for Out of Network Providers (after deductible) |
| Physician Visits (inpatient) | 85% for preferred providers / 60% for non-preferred providers (after deductible) | 85% for Group Health (In-Network) Providers / 60% for Out of Network Providers (after deductible) |
| Physician Visits (outpatient, non-preventive services) | 85% for preferred providers / 60% for non-preferred providers (after deductible) | 85% for Group Health (In-Network) Providers / 60% for Out of Network Providers (after deductible) |
| Diagnostic X-ray and Lab | 85% for preferred providers / 60% for non-preferred providers (after deductible) | 85% for Group Health (In-Network) Providers / 60% for Out of Network Providers (after deductible) |
| Dental Treatment | 85% 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. | 85% 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. |
| Nursing Services (inpatient and outpatient) | 85% for preferred providers / 60% for non-preferred providers (after deductible) | 85% for Group Health (In-Network) Providers / 60% for Out of Network Providers (after deductible) |
| Blood Transfusion | 85% for preferred providers / 60% for non-preferred providers (after deductible) | 85% for Group Health (In-Network) Providers / 60% for Out of Network Providers (after deductible) |
| Medical Supplies and Equipment | 85% for preferred providers / 60% for non-preferred providers (after deductible) | 85% for Group Health (In-Network) Providers / 60% for Out of Network Providers (after deductible) |

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| Prosthetic Devices | 85% for preferred providers / 60% for non-preferred providers (after deductible) | 85% for Group Health (In-Network) Providers / 60% for Out of Network Providers (after deductible) |
| Anesthetic Supplies | 85% for preferred providers / 60% for non-preferred providers (after deductible) | 85% for Group Health (In-Network) Providers / 60% for Out of Network Providers (after deductible) |
| Mental and Nervous Disorder <ul style="list-style-type: none"> <li data-bbox="142 623 296 651">▪ Inpatient <li data-bbox="142 745 317 773">▪ Outpatient | 85% for preferred providers / 60% for non-preferred providers (after deductible) 85% for preferred providers / 60% for non-preferred providers (after deductible) | 85% at GHO approved facility / 60% for Out of Network facilities (after deductible) <ul style="list-style-type: none"> <li data-bbox="1304 699 1814 727">▪ Maximum of 12 days per calendar year 85% for Group Health (In-Network) Providers / 60% for Out of Network Providers (after deductible) <ul style="list-style-type: none"> <li data-bbox="1304 824 1822 852">▪ Maximum of 20 visits per calendar year <li data-bbox="1304 865 1835 893">▪ Excess does not apply to OOP maximum |
| Preventive Care: Well Adult, Well Child, Well Baby Care <ul style="list-style-type: none"> <li data-bbox="142 987 365 1015">▪ Physical Exam <li data-bbox="142 1027 422 1088">▪ Routine Pap Smear, Mammogram <li data-bbox="142 1101 512 1161">▪ Preventive Screenings, Lab Tests <li data-bbox="142 1174 533 1201">▪ 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) | All preventive services covered in accordance with GHO well care schedule: 100% for Group Health (In-Network) Providers (no deductible) 60% for Out of Network Providers (after deductible) |

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| Chiropractic Care | 85% for preferred providers / 60% for non-preferred providers (after deductible) <ul style="list-style-type: none"> ▪ Benefit limited to \$20 per visit ▪ First Choice PPO providers provide a discount ▪ Maximum of 20 visits per calendar year ▪ Excess does not apply to OOP maximum | 85% 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 |
| Podiatry | 85% for preferred providers / 60% for non-preferred providers (after deductible) <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 | 85% for Group Health (In-Network) Providers / 60% for Non-Network and 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 |
| Acupuncture | 85% for preferred providers / 60% for non-preferred providers (after deductible) <ul style="list-style-type: none"> ▪ Maximum of 5 visits per calendar year ▪ Excess does not apply to OOP maximum | 85% 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 |
| Naturopaths | 85% for preferred providers / 60% for non-preferred providers (after deductible) <ul style="list-style-type: none"> ▪ Maximum of 2 visits per calendar year | 85% 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 |

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| Alcoholism and Drug Abuse | 85% 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 | 85% 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 |
| Hearing Aid | 85% 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 | 85% for Group Health (In-Network) Providers / 60% for Out of Network Providers (after deductible) 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 | 85% for preferred providers / 60% for non-preferred providers (after deductible) | 85% 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 |
| Home Health Care | Covered in full <ul style="list-style-type: none"> ▪ Must be in lieu of confinement in hospital or skilled nursing facility ▪ Out of Network Subject to Usual Reasonable and Customary Charges (UCR) | Covered in full <ul style="list-style-type: none"> ▪ Must be in lieu of confinement in hospital or skilled nursing facility ▪ Out of Network Subject to Usual Reasonable and Customary Charges (UCR) |
| Hospice | Covered in full (Out of Network Subject to UCR) | Covered in full (Out of Network Subject to UCR) |

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| Transplant Benefit | 85% for preferred providers / 60% for non-preferred providers (after deductible) <ul style="list-style-type: none"> ▪ Covers only listed procedures | 85% for Group Health (In-Network) Providers / 60% for Out of Network Providers (after deductible) |
| Rehabilitation <ul style="list-style-type: none"> ▪ Outpatient Services ▪ Inpatient Services | 85% 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 85% 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 | 85% 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 85% 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 |

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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) <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>Brand Name Drug with Generic Available: If you fill a prescription for a brand name drug when there is a generic</p> | <p>Purchased at a “Trust Network” Pharmacy – copay per 30-day supply:</p> <p>\$0 copay</p> <p>\$5 copay</p> <p>\$20 copay</p> <p>\$30 copay</p> <p>Generic copay plus the actual difference in cost between the generic and the brand name drug 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> | <p>Copay per 30-day supply:</p> <p>\$0 copay</p> <p>\$5 copay for Generics if on GHO formulary</p> <p>\$20 copay for Brand if on GHO formulary</p> <p>\$30 copay if not on GHO formulary (Brand or Generic)</p> <p>Generic copay plus the actual difference in cost between the generic and the brand name drug.</p> |

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| Maintenance “Mail” at Retail <ul style="list-style-type: none"> ▪ Tier 3 maintenance drugs | Purchased at certain “Trust Network” pharmacies: \$60 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 \$15 copay \$60 copay \$90 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) <ul style="list-style-type: none"> ▪ Must use Group Health Mail Order Program \$0 copay \$15 copay for Generic if on GHO formulary \$60 copay for Brand if on GHO formulary \$90 copay if not on GHO formulary (brand or generic) Not applicable |

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| Vision Benefits | Vision Service Plan (VSP) | 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 consecutive months | 85% for Group Health (In-Network) Providers / 60% for Out of Network Providers, not subject to deductible or coinsurance; once each 12 consecutive months |
| Vision Hardware | <ul style="list-style-type: none"> <li data-bbox="128 574 562 602">▪ Lenses |  <p data-bbox="1402 672 1940 699">Up to \$150; once each 12 consecutive months</p> |
| <ul style="list-style-type: none"> <li data-bbox="128 677 562 704">▪ Frames | 100% at a VSP provider up to \$30 at a non-VSP provider; once each 24 consecutive months | |
| <ul style="list-style-type: none"> <li data-bbox="128 774 562 802">▪ Contact lenses | Up to \$130 at a VSP provider, up to \$55 at a non-VSP provider; once each 12 consecutive months | |

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| Time Loss | <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> <thead> <tr> <th><u>Hours Employed in Eligibility Determination Month</u></th> <th><u>Maximum Weekly Benefit</u></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> | <u>Hours Employed in Eligibility Determination Month</u> | <u>Maximum Weekly Benefit</u> | Less than 80 | \$ 0 | 80 but less than 120 | 135 | 120 but less than 150 | 180 | 150 or more | 225 | <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> <thead> <tr> <th><u>Hours Employed in Eligibility Determination Month</u></th> <th><u>Maximum Weekly Benefit</u></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> | <u>Hours Employed in Eligibility Determination Month</u> | <u>Maximum Weekly Benefit</u> | Less than 80 | \$ 0 | 80 but less than 120 | 135 | 120 but less than 150 | 180 | 150 or more | 225 |
| <u>Hours Employed in Eligibility Determination Month</u> | <u>Maximum Weekly Benefit</u> | | | | | | | | | | | | | | | | | | | | | |
| Less than 80 | \$ 0 | | | | | | | | | | | | | | | | | | | | | |
| 80 but less than 120 | 135 | | | | | | | | | | | | | | | | | | | | | |
| 120 but less than 150 | 180 | | | | | | | | | | | | | | | | | | | | | |
| 150 or more | 225 | | | | | | | | | | | | | | | | | | | | | |
| <u>Hours Employed in Eligibility Determination Month</u> | <u>Maximum Weekly Benefit</u> | | | | | | | | | | | | | | | | | | | | | |
| Less than 80 | \$ 0 | | | | | | | | | | | | | | | | | | | | | |
| 80 but less than 120 | 135 | | | | | | | | | | | | | | | | | | | | | |
| 120 but less than 150 | 180 | | | | | | | | | | | | | | | | | | | | | |
| 150 or more | 225 | | | | | | | | | | | | | | | | | | | | | |
| Life Insurance | <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>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> | | | | | | | | | | | | | | | | | | | | |

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| Accidental Death & Dismemberment | 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. | 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. |
| Nurse Line | 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. | 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. |
| 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. 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. 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. |

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| | SoundPlus (PPO) Plan | Group Health Options (GHO) Plan |
|-----------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 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. The LiveWell Health Coaching program is a phone-based health education program designed to help you set and meet goals to improve your health and well-being. Your health coach will provide you with educational materials, guidance, and the support you need to begin to make healthy lifestyle changes. | 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. |
| Condition Management | Custom-tailored services are available for participants with chronic conditions such as diabetes, heart disease, asthma and other pulmonary diseases. Program participants can work one-on-one with a personal Nurse Advocate to improve both their health and their quality of life. | Custom-tailored services are available for participants with chronic conditions such as diabetes, heart disease, depression, asthma and other pulmonary diseases; or those who need help making decisions about low back pain, breast cancer, prostate disorders, chronic pain, women's health, or end-of-life care. Program participants can work one-on-one with a personal Nurse Advocate to improve both their health and their quality of life. |
| LiveWell Online | 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. | 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. |

This Plan comparison provides a general overview of Plan benefits. Please refer to the Plan Booklet for specifics about covered expenses as well as exclusions and limitations.

FURTHER QUESTIONS?

SoundPlus PPO Medical Option

206-282-4500 or 800-225-7620

(choose member, then the Option you want)

First Choice Preferred Provider Network

www.fchn.com

Group Health Options

www.ghc.org

888-901-4636