

SOUND HEALTH & WELLNESS TRUST

MEDICAL, PRESCRIPTION DRUG AND VISION OPTIONS

FOR

SOUNDPLUS PLAN

2012 ENROLLMENT

Sound Health & Wellness Trust

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

SoundPlus Plan

	SoundPlus (PPO) Plan	Group Health Options (GHO) Plan	Qliance Plan
Prevention @ 100%	All covered in-network preventive care is paid in full - with no deductibles, coinsurance or co-pays.		Preventive care services received at a Qliance clinic are completely covered - with no deductibles, coinsurance or co-pays. (see specific preventive care benefits on page 7.)
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.		
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.	Covered services are available from any covered provider. However, services provided by your Qliance clinic (Downtown Seattle, Kent Station, Mercer Island, Mill Creek (Guardian Family Care, a Qliance affiliate), or Tacoma) will be paid in full. If you use a Preferred Provider from the First Choice network for medical services, your benefits may be paid at either the in network or out of network benefit, depending on the services being provided. See specific benefits below. If you use the Optum Behavioral Health network for mental health and substance abuse services, your benefits will be paid at the in network benefit level. All services provided by non-preferred providers are subject to Usual, Customary and Reasonable (UCR) charges.

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<p>Annual net deductible (per calendar year)</p> <ul style="list-style-type: none"> ▪ Employee Only ▪ Family 	<p>\$250 for preferred providers \$500 for non-preferred providers</p> <p>\$500 for preferred providers \$1,000 for non-preferred 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 Personal Health Assessment (PHA) and choose a Primary Care Physician (PCP) during the available time period, your deductible will be higher.</p>	<p>\$250 for Group Health (In-Network) Providers \$500 for Out of Network Providers</p> <p>\$500 for Group Health (In-Network) Providers \$1,000 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>	<p>There is no deductible for services received at your Qliance clinic. For all other services:</p> <p>\$250 for preferred providers \$500 for non-preferred providers</p> <p>\$500 for preferred providers \$1,000 for non-preferred 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 and take your Personal Health Assessment (PHA) during the available time period, your deductible will be higher.</p>
<p>Annual Out of Pocket (OOP) Maximum (per calendar year)</p> <ul style="list-style-type: none"> ▪ Employee Only ▪ Family <p>Deductible and co-insurance apply to the OOP maximum.</p>	<p>\$2,250 for preferred providers \$4,500 for non-preferred providers</p> <p>\$4,500 for preferred providers \$9,000 for non-preferred 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</p>	<p>\$2,250 for Group Health (In-Network) Providers \$4,500 for Out of Network Providers</p> <p>\$4,500 for Group Health (In-Network) Providers \$9,000 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</p>	<p>\$2,250 for preferred providers \$4,500 for non-preferred providers</p> <p>\$4,500 for preferred providers \$9,000 for non-preferred 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</p>

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SoundPlus Plan

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	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.	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.	same sex domestic partner) do not update your contact information and take your Personal Health Assessment (PHA) during the available time period, your deductible will be higher.
Annual Maximum	\$1,500,000	\$1,500,000	\$1,500,000
Benefit percentages apply after the deductibles have been met (unless otherwise stated).			
Hospital			
▪ Room and Board	85% for preferred providers / 60% for non-preferred providers	85% for Group Health (In-Network) Providers / 60% for Out of Network Providers	85% for preferred providers / 60% for non-preferred providers
▪ Ancillary Services	85% for preferred providers / 60% for non-preferred providers	85% for Group Health (In-Network) Providers / 60% for Out of Network Providers	85% for preferred providers / 60% for non-preferred providers
▪ Emergency Room (Subject to in-network deductible and coinsurance. Copay does not apply to OOP maximum)	\$100 copay, waived if admitted. Life endangering medical emergency at non-preferred hospital covered as if preferred hospital (subject to UCR).	\$100 copay at Group Health and non-designated facilities, waived if admitted. Worldwide emergency care is covered.	\$100 copay, waived if admitted. Life endangering medical emergency at non-preferred hospital covered as if preferred hospital (subject to UCR).
Ambulance (air/ground)	85%	85%	85%
Surgical Services	85% for preferred providers / 60% for non-preferred providers	85% for Group Health (In-Network) Providers / 60% for Out of Network Providers	100% with no deductible for services provided at your Qliance clinic 85% for preferred providers / 60% for non-preferred providers
Anesthesia	85% for preferred providers / 60% for non-preferred providers	85% for Group Health (In-Network) Providers / 60% for Out of Network Providers	85% for preferred providers / 60% for non-preferred providers
Second Surgical Opinion	85% for preferred providers / 60% for non-preferred providers	85% for Group Health (In-Network) Providers / 60% for Out of Network Providers	85% for preferred providers / 60% for non-preferred providers

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Ambulatory Surgical Center	85% for preferred providers / 60% for non-preferred providers	85% for Group Health (In-Network) Providers / 60% for Out of Network Providers	85% for preferred providers / 60% for non-preferred providers
Physician Visits (inpatient)	85% for preferred providers / 60% for non-preferred providers	85% for Group Health (In-Network) Providers / 60% for Out of Network Providers	85% for preferred providers / 60% for non-preferred providers
Physician Visits (outpatient, non-preventive services)	85% for preferred providers / 60% for non-preferred providers	85% for Group Health (In-Network) Providers / 60% for Out of Network Providers	100% with no deductible for services provided at your Qliance clinic / 60% for services outside your Qliance clinic
Diagnostic X-ray and Lab	85% for preferred providers / 60% for non-preferred providers	85% for Group Health (In-Network) Providers / 60% for Out of Network Providers	100% with no deductible for services provided at your Qliance clinic 85% for preferred providers / 60% for non-preferred providers
Dental Treatment	85% 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.	85% 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.	100% with no deductible for services provided at your Qliance clinic 85% 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.
Nursing Services (inpatient and outpatient)	85% for preferred providers / 60% for non-preferred providers	85% for Group Health (In-Network) Providers / 60% for Out of Network Providers	85% for preferred providers / 60% for non-preferred providers
Blood Transfusion	85% for preferred providers / 60% for non-preferred providers	85% for Group Health (In-Network) Providers / 60% for Out of Network Providers	85% for preferred providers / 60% for non-preferred providers

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Medical Supplies and Equipment	85% for preferred providers / 60% for non-preferred providers	85% for Group Health (In-Network) Providers / 60% for Out of Network Providers	100% with no deductible for supplies/equipment provided at your Qliance clinic 85% for preferred providers / 60% for non-preferred providers
Prosthetic Devices	85% for preferred providers / 60% for non-preferred providers	85% for Group Health (In-Network) Providers / 60% for Out of Network Providers	85% for preferred providers / 60% for non-preferred providers
Anesthetic Supplies	85% for preferred providers / 60% for non-preferred providers	85% for Group Health (In-Network) Providers / 60% for Out of Network Providers	85% for preferred providers / 60% for non-preferred providers
Mental and Nervous Disorder <ul style="list-style-type: none"> ▪ Inpatient ▪ Outpatient 	<p>85% for Optum providers / 60% for non-Optum providers</p> <p>85% for Optum providers / 60% for non-Optum providers</p>	<p>85% at Group Health 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>85% 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 	<p>85% for Optum providers / 60% for non-Optum providers</p> <p>85% for Optum providers / 60% for non-Optum providers</p>

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Preventive Care: <ul style="list-style-type: none"> ▪ Physical Exam ▪ Preventive Screenings, Lab Tests ▪ 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 Group Health well care schedule: 100% for Group Health (In-Network) Providers (no deductible) 60% for Out of Network Providers (after deductible)	All preventive services covered in accordance with the Plan's well care schedule: 100% with no deductible for services provided at your Qliance clinic or referred by your Qliance physician. 60% for services outside of or not referred by your Qliance clinic (after deductible)
Chiropractic Care (Excess does not apply to OOP maximum)	85% 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 	85% 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) 	85% 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
Podiatry (Excess does not apply to OOP maximum)	85% 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 	85% for Group Health (In-Network) Providers / 60% for 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 	85% 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
Acupuncture (Excess does not apply to OOP maximum)	85% for preferred providers / 60% for non-preferred providers Maximum of 8 visits per calendar year	85% for Group Health (In-Network) Providers / 60% for Out of Network Providers Maximum of 8 self-referral visits per calendar year; additional visits available when approved by GHO (In-Network)	85% for preferred providers / 60% for non-preferred providers Maximum of 8 visits per calendar year

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Naturopaths (Excess does not apply to OOP maximum)	85% for preferred providers / 60% for non-preferred providers Maximum of 5 visits per calendar year	85% for Group Health (In-Network) Providers / 60% for Out of Network Providers Maximum of 5 self-referral visits per diagnosis per calendar year; additional visits available when approved by GHO	85% for preferred providers / 60% for non-preferred providers Maximum of 5 visits per calendar year
Alcoholism and Drug Abuse (Excess does not apply to OOP maximum)	85% 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. 	85% for Group Health (In-Network) Providers 60% for Out of Network Providers	85% 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.
Hearing Aid (Excess does not apply to OOP maximum)	85% 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 ▪ Rental charges covered for up to 30 days 	85% 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 Group Health physician (In-Network) or with a physician prescription (Out of Network) 	85% 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 ▪ Rental charges covered for up to 30 days
Skilled Nursing Facility	85% for preferred providers / 60% for non-preferred providers	85% for Group Health (In-Network) Providers / 60% for Out of Network Providers Maximum of 60 days per calendar year	85% for preferred providers / 60% for non-preferred providers

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Home Health Care	Covered in full (Out of Network Subject to UCR) Must be in lieu of confinement in hospital or skilled nursing facility	Covered in full (Out of Network subject to UCR) Must be in lieu of confinement in hospital or skilled nursing facility	Covered in full (Out of Network Subject to UCR) 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)	Covered in full (Out of Network Subject to UCR)
Transplant Benefit	85% for preferred providers / 60% for non-preferred providers Covers only listed procedures	85% for Group Health (In-Network) Providers / 60% for Out of Network Providers	85% for preferred providers / 60% for non-preferred providers Covers only listed procedures
Rehabilitation <ul style="list-style-type: none"> • Outpatient Services (Excess does not apply to OOP maximum) • Inpatient Services (Excess does not apply to OOP maximum) 	<p>85% for preferred providers / 60% for non-preferred providers 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</p> <p>85% for preferred providers / 60% for non-preferred providers 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</p>	<p>85% for Group Health (In-Network) Providers / 60% for Out of Network Providers 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</p> <p>85% for Group Health (In-Network) Providers / 60% for Out of Network Providers 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</p>	<p>85% for preferred providers / 60% for non-preferred providers 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</p> <p>85% for preferred providers / 60% for non-preferred providers 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</p>

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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):	Purchased at a "Trust Network" Pharmacy – copay per 30-day supply:
Tier 0: Some highly cost-effective medications	\$0 copay	\$0 copay	\$0 copay
<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) 			
Tier 1: Current Generics, some future generics	\$6 copay	\$6 copay for Generics if on GHO formulary	\$6 copay
Tier 2: Most brand drugs, and more costly or less desirable future generics	\$22 copay	\$22 copay for Brand if on GHO formulary	\$22 copay
Tier 3: Non-Preferred brand drugs and some undesirable future generics	\$35 copay	\$35 copay if not on GHO formulary (Brand or Generic)	\$35 copay
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.	Generic copay plus the actual difference in cost between the generic and the brand name drug

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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	Purchased at certain "Trust Network" pharmacies: \$66 for a 90 day supply
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) <ul style="list-style-type: none"> ▪ Must use GHO Mail Order Program \$0 copay \$18 copay for Generic if on GHO formulary \$66 copay for Brand if on GHO formulary \$105 copay if not on GHO formulary (brand or generic) Generic copay plus the actual difference in cost between the generic and the brand name drug	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


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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	85% for Group Health (In-Network) Providers / 60% for Out of Network Providers (no deductible), once each 12 consecutive months	100% at a VSP provider, up to \$35 at a non-VSP provider after a \$10 copay, 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	 <p>Up to \$150 (no deductible); once each 12 consecutive months</p>	100% at a VSP provider, from \$30 to \$90 at a non-VSP provider; once each 12 consecutive months
▪ 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		Up to \$95 allowance at a VSP provider, up to \$30 at a non-VSP provider; once each 24 consecutive months
▪ 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)		Up to \$130 allowance at a VSP provider, up to \$55 at a non-VSP provider; once each 12 consecutive months (contacts are in lieu of lenses and a frame)
▪ Contact lenses			

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FURTHER QUESTIONS?

SoundPlus PPO or Qliance Medical Options
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