SOUND HEALTH & WELLNESS TRUST

MEDICAL, PRESCRIPTION DRUG AND VISION OPTIONS

FOR

SOUNDPLUS PLAN

2017 ENROLLMENT

Sound Health & Wellness Trust

Comparison of Medical/Prescription Drug/Vision Benefits Effective January 1, 2017

SoundPlus Plan

	SoundPlus PPO Plan	SoundPlus Group Health Options 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 (Omeprazole – generic of Prilosec OTC, with physician prescription), non-sedating antihistamines (Loratadine - 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 Aetna Choice POS II network for medical 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 First Health 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.
Annual net deductible (per calendar year)		
▪ Employee Only	$250 for preferred providers $500 for non-preferred providers	$250 for Group Health (In-Network) Providers $500 for Out of Network Providers
▪ Family	$500 for preferred providers $1,000 for non-preferred providers For family coverage, the deductible applies to the family as a whole. Note: If you (and your enrolled spouse) do not update your contact information, take your Personal Health Assessment (PHA), choose a Primary Care Physician (PCP) and complete health actions during the available time period, your deductible will be higher.	$500 for Group Health (In-Network) Providers $1,000 for Out of Network Providers For family coverage, the deductible applies to the family as a whole. Note: If you (and your enrolled spouse) do not update your contact information, take your Health Profile, choose a Primary Care Physician (PCP) and complete health actions during the available time period, your deductible will be higher.

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Annual Out of Pocket (OOP) Maximum (per calendar year) ▪ Employee Only ▪ Family Deductible and co-insurance apply to the OOP maximum.	$2,250 for preferred providers $4,500 for non-preferred providers $4,500 for preferred providers $9,000 for non-preferred providers Overall in-network out-of-pocket limit on Essential Health Benefits: $7,150 person / $14,300 family For employees with Family coverage, the "Employee Only coverage" maximum will apply to each covered individual until the "Family coverage" maximum is met. Note: If you (and your enrolled spouse) do not update your contact information, take your Personal Health Assessment (PHA), choose a Primary Care Physician (PCP) and complete health actions during the available time period, your out of pocket will be higher.	$2,250 for Group Health (In-Network) Providers $4,500 for Out of Network Providers $4,500 for Group Health (In-Network) Providers $9,000 for Out of Network Providers Overall in-network out-of-pocket limit on Essential Health Benefits: $7,150 person / $14,300 family For employees with Family coverage, the "Employee Only coverage" maximum will apply to each covered individual until the "Family coverage" maximum is met. Note: If you (and your enrolled spouse) do not update your contact information, take your Health Profile, choose a Primary Care Physician (PCP) and complete health actions during the available time period, your out of pocket will be higher.
Hospital ▪ Room and Board ▪ Ancillary Services ▪ Emergency Room (Copay applies only to the Essential Health Benefits OOP maximum.)	85% for preferred providers / 60% for non-preferred providers 85% for preferred providers / 60% for non-preferred providers $100 copay, waived if admitted. Life endangering medical emergency at non-preferred hospital covered as if preferred hospital (subject to UCR).	85% for Group Health (In-Network) Providers / 60% for Out of Network Providers 85% for Group Health (In-Network) Providers / 60% for Out of Network Providers $100 copay at Group Health and non-designated facilities, waived if admitted. Worldwide emergency care is covered.
Ambulance (air/ground)	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

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Anesthesia	85% for preferred providers / 60% for non-preferred providers	85% for Group Health (In-Network) Providers / 60% for Out of Network 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
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
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
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
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
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.
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
Blood Transfusion	85% for preferred providers / 60% for non-preferred providers	85% for Group Health (In-Network) Providers / 60% for Out of Network Providers
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
Prosthetic Devices	85% for preferred providers / 60% for non-preferred providers	85% for Group Health (In-Network) Providers / 60% for Out of Network 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

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Mental and Nervous Disorder • Inpatient	85% for preferred providers / 60% for non-preferred providers	85% at Group Health approved facility / 60% for Out of Network facilities ▪
• Outpatient	85% for preferred providers / 60% for non-preferred providers	85% for Group Health (In-Network) Providers / 60% for Out of Network Providers ▪
Preventive Care: ▪ 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)
Chiropractic Care	85% for preferred providers / 60% for non-preferred providers ▪ Benefit limited to $30 per visit ▪ PPO providers provide a discount ▪ Maximum of 20 visits per calendar year ▪ Chiropractic x-rays limited to one set from one chiropractic visit, per calendar year ▪ Excess of the $30 per visit applies only to the Essential Health Benefits OOP maximum. Excess of the 20 visits per calendar year does not apply to the OOP maximums.	85% for Group Health (In-Network) Providers / 60% for Out of Network Providers ▪ Maximum of 10 self-referral visits for manipulative therapy of the spine and extremities per calendar year; additional visits available when approved by Group Health (In-Network)
Podiatry	85% for preferred providers / 60% for non-preferred providers ▪ Benefit limited to $20 per visit ▪ PPO providers provide a discount	85% for Group Health (In-Network) Providers / 60% for Out of Network Providers ▪ Routine foot care not covered, except in the presence of a non-related medical condition affecting the lower limbs

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	▪ Maximum of 12 visits per calendar year ▪ Excess of the $20 per visit and 12 visits per calendar year applies only to the Essential Health Benefits OOP maximum	
Acupuncture (Non-covered visits 9 through 12 apply only to the Essential Health Benefits 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 Group Health (In-Network)
Naturopaths	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 calendar year; additional visits available when approved by Group Health (in Network)
Hearing Aid	85% for preferred providers / 60% for non-preferred providers ▪ 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 ▪ 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)
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
Home Health Care	100% for preferred providers (no deductible) / 60% for non-preferred providers ▪ 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	100% for preferred providers (no deductible) / 60% for non-preferred providers	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

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Rehabilitation		
▪ Outpatient Services	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	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
▪ Inpatient Services	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	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
Alcoholism and Drug Abuse	80% for preferred providers / 60% for non-preferred providers	80% for Group Health (In-Network) Providers / 60% for Out of Network Providers

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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):
Tier 0: Some highly cost-effective medications ▪ Cholesterol Lowering Medications (Simvastatin) ▪ Proton Pump Inhibitors (Omeprazole – generic of Prilosec OTC, with physician Rx) ▪ Non-sedating Antihistamines (Loratadine - generic of 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 Group Health formulary
Tier 2: Most brand drugs, and more costly or less desirable future generics	$22 copay	$22 copay for Brand if on Group Health formulary
Tier 3: Non-Preferred brand drugs and some undesirable future generics	$35 copay	$35 copay if not on Group Health formulary (Brand or Generic)
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.

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Maintenance "Mail" at Retail ▪ Tier 3 maintenance drugs	Purchased at certain "Trust Network" pharmacies: $66 for a 90 day supply	Not available
Mail Order ▪ 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) ▪ Must use Group Health Mail Order Program $0 copay $18 copay for Generic if on Group Health formulary $66 copay for Brand if on Group Health formulary $105 copay if not on Group Health formulary (brand or generic) 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 $50 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
Vision Hardware ▪ Lenses	100% at a VSP provider, from $50 to $100 at a non-VSP provider; once each 12 months from last date of service	Up to $150 (no deductible); once each 12 consecutive months (Amounts over $150 apply to the Essential health Benefits OOP maximum)
▪ Frames	Up to $95 allowance at a VSP provider, up to $70 at a non-VSP provider; once each 24 months from last date of service	
▪ Contact lenses	Up to $60 copay for contact lens exam (fitting and evaluation) $130 allowance contact lenses at a VSP provider, up to $105 at a non-VSP provider; once each 12 months from last date of service (contacts are in lieu of lenses)	

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FURTHER QUESTIONS?

SoundPlus PPO Plan
206-282-4500 or 800-225-7620
(Choose member, then option 1)

SoundPlus Group Health Options Plan
888-901-4636